TRYING TO FIT IN, YET STANDING OUT

- Psychological Consequences of Rape and Attempted Rape, Psychotherapeutic Treatment and the Process of Recovery

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2008
PREFACE AND ACKNOWLEDGEMENTS

The topic of this study is sexual assault, focusing on victims’ psychological reactions post assault and the process of recovery.

The dissertation consists of three articles based on studies carried out in 2001-2006 at the Centre for Victims of Sexual Assault (CVS), Copenhagen University Hospital, Denmark, where the researcher is employed.

CVS opened in March 2000 as a National centre of knowledge and treatment, which implied that an important part of the psychological function was to collect information within the field of sexual assault, and to communicate the experiences and expertise achieved in contact with victims enquiring at the centre.

The articles included in the dissertation are

I. Rust, A.: Sexual Assault, Acute Stress Disorder and Influential Variables.

II. Rust, A.: Long-term Consequences of Sexual Assault: A Follow-up Study.

III. Rust, A.: Acute and Long-term Psychotherapy of Victims of Sexual Assault including Hypnotic Techniques.

Acknowledgements

I wish to thank:

First of all the participants in the studies.
Svend Aage Madsen, who has supported me with his general enthusiasm and experience in the field of research.
Signe Rakel Sørensen for her professional assistance as interviewer of the women in the follow-up study.
Charlotte Gerd Hannibal, Jeanette Pinnerup Jensen, Mia Madsen, Marie Mohr and not least Pernille Kæstel for invaluable assistance in statistical calculations.
Eline Grell for proofreading and suggestions of correcting my ‘danglish’ language.
CVS for giving me the opportunity to carry through the study by accepting my part time leave from CVS and the inconveniences caused by my absence.
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DANSK RESUMÉ


De anvendte psykologiske interventionsprocesser er beskrevet ud fra en fortolkende analyse af forskerens egne systematiske journaloptegelser fra seks psykologiske behandlingsforløb. De anvendte metoder og tilhørende data er beskrevet i afhandlingens tre artikler.


Teori og analysemodel: Afhandlingens videnskabelige forankring og metodologi ligger overvejende indenfor det psykefysiologiske, kognitive og psykedynamiske område. Teorierne, der i afhandlingen danner grundlag for analyse og fortolkning af de enkelte delundersøgelsers resultater, repræsenterer en psykologisk tilgang, der tager udgangspunkt i det enkelte individs reaktioner og
subjektive forståelse og oplevelse. I undersøgelsen af både akutte og længerevarende reaktioner på et seksuelt overgreb har fokus været på seks udvalgte variable, der er undersøgt med henblik på, om de har haft en indvirkning på kvindens reaktioner såvel som på hendes opfattelse og vurdering af hændelsen. De seks variable er:

- Kvindens alder på overgrebstidspunktet.
- Kvindens indtagelse af alkohol/og eller narkotika før overgrebet.
- Kvindens oplevelse af egen modstand under overgrebet.
- Overgrebets art (voldtægt/voldtægtsforsøg).
- Vold eller trusler om vold fra overgriberen.
- Kvindens kendskab til overgriberen før overgrebet.

De psykologiske interventioner, der har været anvendt er baseret på terapeutiske principper om, at en person efter en traumatisk oplevelse har brug for en terapeutisk behandling, der bygger på stabilisering og integrering på forskellige funktionsniveauer af de forandringer og forstyrrelser, som et seksuelt overgreb kan medføre.

**Resultater:** Undersøgelsene viste, at en voldtægt eller et voldtægtsforsøg kan have alvorlige konsekvenser for ofret på kort og længere sigt. I forhold til de områder, afhandlingen belyser, viste det sig:

- at 88 procent af de 50 kvinder, der blev undersøgt i forhold til Acute Stress Disorder (ASD) diagnosticeredes som lidende af ASD (artikel I). Yngre voldtægtsofre og ofre, som ikke havde indtaget alkohol og/eller narkotika før overgrebet havde de alvorligste akutte efterreaktioner;

- at 50 procent af de 28 kvinder, der blev undersøgt i forhold til Post Traumatisk Stress Disorder (PTSD) diagnosticeredes som lidende af middel til svær PTSD (artikel II). Yngre voldtægtsofre og ofre, som ikke havde indtaget alkohol og/eller narkotika før overgrebet havde de alvorligste længerevarende efterreaktioner;

- at 25 af de 28 kvinder, der blev undersøgt i forhold til PTSD rapporterede at overgrebet havde medført betydelige fysiske og psykiske belastninger udover overgrebet (artikel II);
at de vigtigste problemstillinger, der blev berørt i de 6 cases, som undersøgelsen af den psykoterapeutiske behandlingsproces omfattede, vedrørte bearbejdning af psykefysiologiske eftervirkninger af overgrebet og relationelle forhold (artikel III).

Konklusion og anbefalinger: Afhandlingen belyser, hvordan en voldtægt eller et voldtægtsforsøg kan være alvorligt traumatiserende for ofret på kort og længere sigt. Undersøgelserne viser, at overgrebet kan få konsekvenser, der indvirker på adskillige områder af ofrets tilværelse. Derfor har fokuspunktet i den beskrevne psykologiske behandling været stabilisering i forhold til de forandringer, overgrebet har medført, så kvinden har kunnet handle, værdsætte sig selv og sin krop, samt være tryg i sin hverdag på trods af overgrebet.


Derfor anbefales det, at den psykologiske behandling, der tilbydes voldtægtsofre omfatter både akut behandling og mulighed for opfølgende kontakt i forhold til senere opståede eftervirkninger af overgrebet.

ENGLISH SUMMARY

This dissertation includes three articles on psychological aspects concerning women exposed to rape or attempted rape. The group of women included in the research have attended psychological treatment at the Centre for Victims of Sexual Assault (CVS), Copenhagen University Hospital. The overall objective of the research has been to examine psychological consequences of rape and attempted rape in the short as well as in the long term. In order to diminish the consequences of the assault, the purpose has furthermore been to illustrate and discuss the kind of psychological interventions employed. The aim of the research has been to elucidate psychological factors and variables that may enter into prevention of adverse effects of a sexual assault.
Design and methods: The survey has been carried through by using quantitative as well as qualitative methods, and it comprises standardised interviews as well as interviews developed specifically for the purpose of this research. Assessment of acute responses to sexual assault was made on 50 women by means of interviews according to the diagnosis of Acute Stress Disorder (ASD). Assessment of reactions of longer duration was made on 28 women by means of interviews according to the diagnosis of Posttraumatic Stress Disorder (PTSD). Information on self-reported conceptions concerning the assault was attained from the same 28 women using a semi-structured interview-form: The Copenhagen Rape Experience Interview (CREI).

The description of the psychological interventions employed is based on an interpretative analysis of the researcher’s systematic psychological records of six therapies. The methods applied and the data employed are described in the three articles of the dissertation.

Participants: The background material of the research was based on the 994 enquiries at the Centre for Victims of Sexual Assault (CVS) through the years 2001-2004. The number of participants in the various studies of the research represents parts of this base population. The number varies according to themes and issues examined, selection of methods and dropouts.

Theory and model of analysis: The scientific bases and methodology of the research are primarily concentrated within psychophysiological, cognitive and psychodynamic fields. The theories, which form the basis for analysis and interpretation of the results of the research, represent a psychological approach based upon individual reactions and subjective comprehensions and experiences. In the studies of acute and long-term reactions to a sexual assault the focus has been on six selected variables. The variables have been examined with reference to the influence they may have on the woman’s reactions as well as on her comprehension and evaluation of the experience. The six variables are:

- The woman’s age at the time of the assault.
- The woman’s intake of alcohol/and or drugs before the assault.
- The woman’s experience of own resistance during the assault.
- The type of assault (rape/attempted rape).
- Physical violence or threats of violence from the perpetrator.
The relationship between the woman and the perpetrator before the assault.

The psychological interventions employed are based on therapeutic principles saying that a traumatised individual needs to be re-stabilised and have the trauma integrated at different levels of functioning in order to adapt to the changes and disconnections that the trauma has caused.

Results: The studies indicated that an experience of rape or attempted rape might have serious short as well as long-term consequences for the victim. In relation to the themes and issues examined in the research it was found

- That 88 percent of the 50 women, who were assessed in relation to Acute Stress Disorder (ASD) were diagnosed as suffering from ASD (Article I). Younger victims and victims who had not had an intake of alcohol and or drugs before the assault exhibited the most severe acute symptoms;

- That 50 percent of the 28 women, who were assessed in relation to Posttraumatic Stress Disorder (PTSD) were diagnosed as suffering from medium to severe PTSD (Article II). Younger victims and victims who had not had an intake of alcohol and or drugs before the assault exhibited the most severe long-term symptoms;

- That 25 of the 28 women assessed in relation to PTSD reported considerable physical and psychological strains besides the assault (Article II);

- That the most important themes and issues presented in the 6 cases included in the study of the psychotherapeutic treatment, concerned coming to terms with psychophysiological and relational consequences of the assault (Article III).

Conclusion and recommendations: The research elucidates how rape and attempted rape can be seriously traumatising for the victim in the short and long-term. The studies indicate that the assault may have consequences affecting several areas of the victim’s life. Therefore the point of focus of the psychological treatment described has been on stabilisation in relation to the changes the assault has caused. The objective of the psychological treatment has been to mobilise the victim’s strength
to cope with the situation, to appreciate herself and her body, and to feel safe in her everyday life, in spite of the assault.

The results of the studies indicate the importance of an instant psychological support that may contribute to prevent or diminish the occurrence of adverse effects of rape and attempted rape. The results also indicate a need of long-term therapy, since events and experiences following the assault may provoke memories of the assault and result in relapses into reactions connected to the trauma. It is therefore suggested that the psychotherapy offered to victims of sexual assault include immediate treatment as well as a possibility of follow-up contact in relation to recurrent complaints.
INTRODUCTION

The empirical history of research in rape began in the 1970’s with Susan Brownmiller’s pioneering work on the politics of rape (Brownmiller, 1975). Brownmiller was a radical feminist, journalist and activist and her work lead to the groundbreaking research by Burgess and Holmstrom on immediate and long-term effects of rape described as The Rape Trauma Syndrome (RTS) (Burgess & Holmstrom, 1974) (Appendix D, p. 199). RTS is now among some researchers considered a subcategory of Posttraumatic Stress Disorder (PTSD) (Walker, 2000; Hazelwood & Burgess, 2001), a diagnosis introduced in 1980. In the past 35 years several international studies have confirmed that there are serious problems related to an experience of rape; yet, in Denmark research in rape is still only in the making.

International studies indicate that sexual assault is one of the most devastating psychological traumas in both men and women, and subsequently to a sexual assault there is a great risk of developing PTSD (Burgess & Holmstrom, 1974; Bownes, O’Gorman & Sayers, 1991; Gavrinadou, 2001).

Studies have pointed out that rape is a threat to physical integrity (Dahl, 1993; Herman, 1992). Many victims experience rape as a life-threatening situation (American Psychiatric Association, 2000), resulting in anxiety and phobic reactions as specific long-lasting problems (Rose, 1986; Falsetti & Resnick, 1997; Rotschild, 2000).

Feelings of loss of basic trust and confidence in others have also been found to be prominent in rape victims (Kilpatrick, Veronen, Best, 1985; Rust, 2003).

Researchers thus seem to agree to rape as a serious trauma, but it is still unclear which aspects and factors related to an experience of rape that may be predictive in relation to development of posttraumatic stress: Is post traumatic stress influenced by aspects of the rape situation itself, e.g. violence being used and acquaintanceship between victim and perpetrator? Is development of posttraumatic stress connected to conditions and circumstances of the individual victim, e.g. prior traumatic experiences? Does subsequent strain and support from other people post trauma have an impact on the victim’s reactions? In what ways may differences of moral and culture among countries influence prevalence of rape and reactions to it?
Sexual assault in a Danish context

Since centres for victims of sexual assault are relatively new in Denmark, knowledge within the field of rape in a Danish population is still limited, as mentioned above. Thus there is a need of documentation of the specific character and severity of rape-related problems as they are played out in a Danish context.

Through the psychological contact with individual victims of sexual assault it is possible to gain experience, information and understanding of their sufferings and of how to deal with these sufferings therapeutically. To mitigate consequences of sexual assault in general, however, empirical discovery is important as guidelines for understanding, development, and practice for professionals, who deal with sexual assault victims.

Findings from European and American studies may be applicable to a Danish population; yet specific Danish “cultural codes” (Dahl, 1993) may influence reactions and treatment. “In relation to rape, cultural attitudes and beliefs are of particular importance given the confusing and ambiguous attitudes surrounding such an event” (Dahl, 2003, p. 8). Sexual violence and force exist in all cultures, but women in “liberal” countries (i.e. Western Europe and America) are usually considered more in charge of their sexual relationships than women in other parts of the world. Denmark is regarded as a society with a very liberal morality concerning sexual behaviour. Generally, it is also accepted that women as well as men consume alcohol. According to The National Health Service of Denmark the Danish youth possess the European record of drinking: Ninety-three percent of boys and 90% of girls between 16-20 years of age drink alcohol (Ringgaard, Nissen & Nielsen, 2005). It is possible that this Danish liberal view as regards sex and alcohol may influence conceptions of rape as well as attitudes to victims of rape.

Research on a sample of Danish women concerning acute and long-term consequences of rape, possible predictors of traumatisation, and studies on psychological treatment will be reviewed in the three articles of the present dissertation.

1 Culture is defined as “a normative system, integral to which are norms, rules, and other indicators of how people should “behave” in particular roles or particular places” (Moghaddam, Walker & Harré, 2003, p.114).
Aim of the present research

The overall aim of the present research has been to contribute to the understanding of psychological reactions in victims of sexual assault and to elucidate how this knowledge can be used in planning and practicing psychological treatment.

The research includes three studies described in three articles:

Article I: Sexual Assault, Acute Stress Disorder, and Influential Variables. The article is based on assessment of acute stress reactions in 50 women referred for psychological treatment at the Centre for Victims of Sexual Assault (CVS), Copenhagen.

Article II: Long-term Consequences of Sexual Assault: A Follow-up Study. The article includes a follow-up assessment of long-term reactions in 28 women, who had taken part in study I.

Article III: Acute and Long-term Psychotherapy of Victims of Sexual Assault including Hypnotic Techniques. The article is based on an examination of the psychological treatment process of 6 women, who had taken part in study I and II.

The following research questions for the three studies were asked:

- Which factors related to the assault may influence responses in the short and long term? (Articles I and II). It is hypothesised that the victim’s intake of alcohol and/or drugs before the assault, her resistance during the assault, the type of assault, physical violence or threats of violence from the perpetrator, and the relationship between the woman and the perpetrator are factors of special importance in relation to development of post traumatic stress.

- Which influence may subsequent events (report to the police, network support, etc.) have on reactions in the aftermath of the assault and on the process of recovery? (Article II). It is hypothesised that the process of recovery is impeded if the victim experiences additional strain in her life subsequent to the assault.

- Are there personal characteristics and circumstances, which seem to be of special importance in relation to reactions to a rape experience and the process of recovery?
(Articles II and III). It is hypothesised that the victim’s age at the time of the assault, her family background and earlier life experiences influence post trauma reactions and recovery.

- Which aspects should be taken into account in psychotheraputic treatment of victims of rape or attempted rape? (Articles I, II and III). It is hypothesised that rape or attempted rape is experienced as an invasion of body and mind, a personal violation that may influence all aspects of the victim’s life and all levels of functioning, which implies a need of flexible therapeutic techniques and methods accommodated to meet the victims at the levels and functions affected.

BACKGROUND FOR THE RESEARCH

Background factors in relation to the present research concern three issues:

- The history and functioning of the context in which the research took place.
- The researcher’s preliminary studies relevant for comparison with the present research.
- Considerations concerning the meaning of rape and concepts related to the experience of rape as well as theoretical comprehensions of how the experience of rape may influence the individual.

History and functioning

When the feminist movement in Denmark took shape in the 1970’s, the Joan Sisters was established on a voluntary basis as an offer of counselling and support to rape victims (Carstensen, Kongstad, Larsen & Rasmussen, 1981; Joan-Søstrene, 2005). Still, it was not until some thirty years later that public rape crisis centres became a reality in Denmark.

In 1987 the Danish Ministry of Justice concluded from a number of studies concerning rape (Justitsministeriet, 1987) that women exposed to sexual assault are at risk of developing serious psychological problems that imply ”an immediate and not inconsiderable need of treatment” (Justitsministeriet, 1987).
Based on the report from the Ministry of Justice (Justitsministeriet, 1987) the Centre for Victims of Sexual Assault (CVS) at Copenhagen University Hospital was established in 2000 financed provisionally by the Ministry of Health as a four-year research project. Guidelines for the functioning of the centre were published by the National Board of Health October 1998 (Sundhedsstyrelsen, 1998). The purpose was to establish a ward in a safe setting that could ensure the need of acute care, forensic examination, counselling, and treatment for victims of sexual assault. Concerning the psychological part, the guidelines (Sundhedsstyrelsen, 1998) emphasised that it was desirable by the establishment of CVS, that the victims should not themselves look for the relevant support and treatment; that the victims were kept in treatment for a sufficiently long period or if necessary were ensured referral to possibilities of longer-lasting follow-up treatment; and that the victims were observed for a longer period of time.

Admission to CVS
Since 2004 CVS has been a permanent offer to victims of acute sexual assault. The centre is now financed from the Danish government via The Capital Region of Denmark (Region Hovedstaden). CVS functions as a co-operation between two clinics in Copenhagen University Hospital: The Gynaecological Clinic and the Department for Psychology, Play Therapy and Social Counselling. CVS is situated in a gynaecological ward, which is open 24 hours a day. Admitted to the centre are victims of acute rape and attempted rape, preferably within 72 hours after the assault. Access can be direct and report to the police is not obligatory. Treatment is carried out under discretion and it is possible for the victims to stay anonymous, since the registration is separated from other registration in the hospital. Examination and treatment is free of charge and is carried out by a team of professionals such as nurses, gynaecologists, social counsellors, psychologists and forensic doctors.

The centre admits 250-350 victims of sexual assault a year for examination and treatment. By the end of 2006, 1764 women and 27 men\(^2\) have been treated at CVS. The victims have been between 12 – 94 years of age, and 40-50 percent a year has received psychological treatment at the centre, immediately following the first medical examination.

The large number of enquiries offers a solid material for research.

\(^2\) As regards male victims of sexual assault this is a special field attended to at CVS (Center for Voldtægtsofre, 2006), but yet not examined in detail.
The experience in Denmark before the establishment of rape crisis centres was that only few rape victims sought out psychological treatment (Hallmann, 1997). With the establishment of CVS the expectation was that a great deal of the acute problems and long-lived consequences of a rape-trauma could be prevented by an immediate and qualified intervention. A psychologist was employed at the centre with the purpose of examining the possibilities of preventing long-term psychological harms of a sexual assault. Establishment of a psychological service at the centre was meant to open up the possibilities of registration, research and development concerning psychological treatment of rape victims (Sundhedsstyrelsen, 1998).

The National Board of Health (Sundhedsstyrelsen, 1998) specifically called for a description of the psychological consequences of rape and the effect of acute psychological treatment; of the coping mechanisms in victims of rape; and of risk behaviour/risk factors of rape (with reference to prophylaxis).

The present research has been inspired by these objectives.

**Preliminary studies**

Leading up to the present studies the researcher has carried out a number of smaller studies at CVS in order to gain insight into the diversity of psychological aspects and consequences of rape. These preliminary studies have guided the researcher in framing questions and formulating hypothesis for the present research.

In 2001 a retrospective study was done (Rust, 2001) based on medical and psychological records of the 158 enquiries in 2000, the year CVS was founded. Reactions to sexual assault were registered and analysed, and a comparison of personal and demographic variables was made between those who accepted psychological treatment, and those who did not.

For those who accepted psychological treatment more than one third reported having been exposed to one or more traumatic events previously, mainly sexual traumas (Rust, 2001). The victims who declined treatment or ended it after one or two sessions seemed in comparison to have had an even higher level of psychosocial strain at the time of or prior to the assault, e.g. incest, previous rapes, violent partnerships, alcoholism or substance abuse.

In order to improve the psychological treatment to meet the needs of each individual victim a thorough investigation of reactions in rape victims was considered to be essential. An important
aspect of this investigation was to assess the level of traumatisation, which was one purpose of the present research.

Another retrospective study has been carried out with 154 victims, who in 2001 and 2002 received psychotherapy from the researcher at CVS (Rust, unpublished pilot study 1). Based on the researcher’s psychological records an examination and analysis was made of individual reactions to the assault and of the influence of other consequences following the assault (e.g. network support and experiences connected to police reporting). The study was carried out as a pilot study for the present research and information on reactions deducted from the records were compared to symptoms included in the diagnosis of ASD (Appendix A, p. 186) and PTSD (Appendix B, p. 191) (American Psychiatric Association, 2000). The conclusion of the study was that the victims seemed to have a high level of posttraumatic stress, but also that the consequences of the assault for the victims’ lives were more extensive and varied than what the diagnosis of ASD and PTSD encompass. In order to identify rape-related consequences the researcher found it necessary to examine broader aspects of the individual victim’s life than those included in the diagnosis of ASD and PTSD.

In 2001 a follow-up interview concerning somatic, emotional, social and cognitive reactions was carried out six months post-assault with eight victims who had attended psychological treatment at CVS (Rust, unpublished pilot study 2). The experiences from this study and pilot study 1 from 2001-2002 were applied to design the questions of the Copenhagen Rape Experience Interview (CREI, Appendix C, p. 195) used in articles II and III of the present dissertation.

**Theoretical considerations**

**Conceptual framework**
The following section covers the definitions of the most relevant terms and concepts that have been employed for the studies. Rape itself is defined, along with a discussion on variables that influence definitions of rape.

*Rape*

“The interpretation and meaning of a rape event is not a straightforward matter” (Dahl, 1993, p. 2).
Is rape to be seen as sex or violence? There are discussions among researchers and in feminism concerning the importance of the sexual aspect for the victim compared to aspects of power, dominance and suppression (Buss & Malamuth, 1996).

The pioneers within the field of rape research considered rape as “an act of violence, with sex as the weapon” (Brownmiller, 1975; Burgess & Holmstrom, 1979). Ann Burgess (psychiatric nurse) and Lynda Holmstrom (sociologist) saw the act of rape as an instrument for male dominance and power; a means of possessing and controlling women and keep them in a state of fear (Burgess & Holmstrom, 1979). This definition comes close to the definition of the statutory provisions of the criminal law of Denmark (§216 and 217) (Appendix G, p. 205), which, besides penetration, demands violence, or threats of violence as criteria for registration of a sexual act as rape; a definition that limits the extent of rape as a criminal act (Sanday, 1996; Rust, 2005).

Although rape sometimes is experienced as a violent act this definition is not sufficient, since many victims do not experience the assault as violent, and they often blame themselves ‘for letting it happen’ (Rust, 2005). The problem for the system of justice as well as for the victim may be to differentiate between rape and sexual intercourse, where the man ‘possesses’ the woman, and the woman wants to be possessed as a part of the sexual interplay. But rape is a gross distortion of a sexual intercourse, where the victim’s body is turned into an object of exploitation.

In the present research rape is viewed from the perspective of the victim, and is defined as ‘non-consensual sex.’ When we talk about rape we talk about non-consensual vaginal, anal, or oral penetration. The same kind of action that does not lead to penetration is defined as attempted rape. Consent means to agree and assent to the sexual act; non-consent means that the act took place against the person’s will.

In the registration form applied at CVS rape is divided into four categories according to the relationship between victim and perpetrator before the rape:

1. Partner/ex-partner or family (there is or has been an emotional or social relationship between victim and perpetrator before the assault).
2. Friend or other close acquaintance (the relationship has lasted more than 24 hours).
3. Acquaintance or ‘date’ (the relationship has lasted 24 hours or less).
4. Unknown perpetrator/stranger (no relationship before the rape).

This distinction was also applied in the present research, although a categorisation of rape may imply a risk of grading rape according to opinions of the seriousness of the assault. *Date rape*, for example, is a concept charged with moral undertones.

It would be preferable to look at how rapes are similar to each other instead of how they differ from each other.

Rape may be considered as part of a broader continuum of sexual assault, which also includes attempted rape, child abuse, sexual harassment, stalking and cyber stalking, some sorts of domestic violence, and intimidation (Hazelwood & Burgess, 2001).

When the concept *assault* or *sexual assault* is used in the present text it covers *rape* and *attempted rape*. *Acute sexual assault* refers to rape or attempted rape that has taken place within the last four weeks.

*Rape as Trauma*

In DSM-IV (American Psychiatric Association, 2000) and ICD-10 (WHO, 1994) rape is considered a subcategory of trauma.

The concept of *trauma* originates from the field of medicine, where it refers to a serious or critical bodily injury, wound, or shock (Selye, 1984). Exposure to physical harm mobilises the total biological organism: Initially an alarm-shock phase occurs followed by a phase of resistance, where the defences of the organism are activated. If the injury is severe, the resistance is increased, and the defence mechanisms are exhausted, which may cause severe physical harm, and at worst death (Selye, 1984). This model has been applied to psychological ‘injuries’.

Trauma may be conceptualised as 1) events, 2) experiences or 3) reactions.

1) A traumatic event is defined as “an event that involves actual or threatened death or serious injury or a threat to the physical integrity of self and others” (American Psychiatric Association, 2000, p. 467), that is, an extraordinarily extreme event.

2) A traumatic experience is defined as the person’s conception of an event as traumatic (American Psychiatric Association, 2000). It can be useful to differentiate between the
individual person’s experience and the event itself, since what is experienced as traumatic depends on the individual person. It is well known that people do not react the same way when they are exposed to the same kind of trauma (van der Kolk, McFarlane & Weisaeth, 1996; O’Donnell, Creamer & Pattison, 2003). Not everybody is traumatised by exposure to trauma, and the level of traumatisation can be influenced, not only by the category of traumatic event, but also by other factors connected to the event, to the individual victim, and to events and experiences subsequent to the assault.

3) Traumatic reactions according to DSM-IV (American Psychiatric Association, 2000, p. 467) are feelings of “intense fear, helplessness or horror”, which are essentially normal responses to an extremely stressful event.

A concept of trauma according to the classification of the World Health Organisation (WHO, 1994) demands only fulfilment of the first criterion mentioned above, which presupposes that all persons exposed to a traumatic event are affected in the same way. The criteria of DSM-IV demands that all the above-mentioned three criteria must be fulfilled. In the present study the DSM-IV classification is considered more adequate when we are dealing with rape victims, and for that reason the DSM-IV classification is chosen as reference for the present study. This will be elaborated further in Article II.

The organism is biologically prepared for three reactions when it is exposed to danger: *Fight, flight or ‘freezing’* (tonic immobility) (Christianson, 1997; van der Kolk, 1996; Rotschild, 2000; Barlow, 2004). Traumatic responses are activated when none of these reactions are helpful in avoiding the danger of the situation, and the victim’s organism is overwhelmed.

Today the concept of trauma is a concept of everyday language like the concept of crisis (Leymann, 1989). A trauma is put on the same footing as ‘getting a turn’ or ‘to break down and cry.’

The concept of crisis refers to an individual’s state or condition following critical incidents (Cullberg, 2007). A crisis may elicit a broad range of reactions that are normal reactions, i.e. a crisis should not be considered as a disorder. Crisis reactions elicited by traumatic events are termed traumatic crises.
Which aspects that may influence traumatisation and healing are important to examine as guidelines for the subsequent treatment. The therapeutic needs may differ both in interventions and length of therapy depending on the type of trauma. In that respect it may be convenient to differentiate between what is named Type I trauma (a single trauma) and Type II trauma (repeated traumas) (Brown & Fromm, 1986; Rotschild, 2000). Type I trauma includes rape, bank robbery, the death of a close relative etc., while Type II traumas are more complex, longer-lasting traumas, as for example incest.

*Rape, Trauma and stress*
Trauma is closely connected to the concept of *stress*: the non-specific response of the body to any demand (Selye, 1984). A *stress factor* is a demand to which there is no immediate or automatic adaptive response (Antonovsky, 2000). The concepts of *trauma* and *extreme stress* are used synonymously (American Psychiatric Association, 2000). The stress provoked by exposure to an “extraordinarily extreme event” (American Psychiatric Association, 2000) may elicit physiological as well as psychological reactions in the individual.

*Victimisation*
Trauma may be understood as becoming a victim, with the associated feelings of helplessness, humiliation, pain and fear.

The original meaning of the concept of victim in the early antique was: An animal selected for sacrificing (Symonds, 1975). Being a victim means that someone or something makes you suffer. Researchers, professionals and also lay people all discuss the use of the term *victim* in relation to rape (Sanday, 1996; Koss & Cleveland, 1997). There is a risk of marginalisation and stigmatisation of the person in using the term ‘rape victim’, because not only does it portray the person exposed to rape as helpless, but, since most rape victims are women, it may present an image of women in general as helpless and frail, compared to strong, powerful men. Being a victim may be perceived as a *mental defeat* (Ehlers, Maercker & Boos, 2000) that is, as a loss of all autonomy. The concept of mental defeat will be elaborated below in the paragraph on cognitive and psychodynamic dimensions of trauma.

*Secondary victimisation* means that experiences e.g. medical examination or contact with the police following the rape may re-victimise the individual.
Summary
To sum up the conceptual framework, rape in the present research refers to non-consensual vaginal, anal, or oral penetration. If the act has not led to penetration it is defined as attempted rape. For parts of the research it has been convenient to apply a division of the term rape according to the relationship between victim and perpetrator. The paradigm used as a framework for the studies of the consequences of a rape experience is that rape is a traumatic event, and the theoretical structure and former studies reviewed for describing these consequences is thus selected primarily from this point of view. The theoretical framework of the research will be reviewed in the next section.

Theoretical framework
The trauma of rape is complex and therefore multifaceted approaches are needed in order to understand and describe these complexities.
Since rape is a psychological as well as a bodily invasion, a psychophysiological frame of reference will be emphasised. Psychophysiology deals with the study of connections between psychological processes and bodily reactions (Rossi, 1993). Bodily reactions are non-verbal and subconscious. Since rape is a ‘man-made’ trauma, cognitive processes and interpersonal relations may be affected. Psychological theories concerning cognitive-behavioural and psychodynamic aspects have been used as frames of reference for the present research in explaining reactions following extreme stress. The theoretical framework for the present research will be introduced under two headlines: ‘Psychophysiological dimensions of trauma’ and ‘cognitive and psychodynamic dimensions of trauma.’ The order of introducing the phenomena and concepts applied as frames of reference for the present research was aimed to follow the order of issues and themes as they are described and discussed in the three articles of the dissertation. That is, an order of introduction starting with acute phenomena occurring in rape victims moving on to phenomena understood as long-term consequences of a rape experience. At the same time the order followed is a movement from psychobiological levels of functioning, i.e. nonverbal, unconscious levels to cognitive and psychodynamic levels of functioning, i.e. verbal and conscious levels including interpersonal interactions.
Psychophysiological dimensions of trauma

Being exposed to a trauma may be experienced as a life-threatening situation, which causes the individual to function in an instinctive ‘survival mode’ (Foa, Zinberg & Rothbaum, 1992) with a focused attention on aspects and reactions of survival value. Reactions frequently observed in individuals in the immediate aftermath of a psychological trauma are symptoms included in the diagnosis of Acute Stress Disorder (ASD): Dissociation, invasion, avoidance and hyperarousal (American Psychiatric Association, 2000).

Dissociation, invasion and hyperarousal can be understood as mainly biological and psychophysiological reactions, i.e. nonverbal, unconscious reactions outside the person’s voluntary control. Avoidance reactions may be involuntary, but they are mainly considered as voluntary mental and behavioural attempts to ensure survival and restore equilibrium (Horowitz, 1997; Barlow, 2004).

Dissociation: Exposure to extreme traumatic stress, such as a sexual assault, may cause a sudden discontinuity in experience (Spiegel, 1997) resulting in the phenomenon of dissociation. Dissociation is a neurobiological phenomenon (van der Kolk, 1986; Krystal, Bennett, Bremner, Southwick & Charney, 1996), which constitutes the main criteria of the diagnosis of ASD (American Psychiatric Association, 2000). It is defined in DSM-IV (American Psychiatric Association, 2000, p. 519) as “a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment.” To dissociate is to disconnect - the opposite of association, i.e. to connect or combine. Dissociation may be regarded as a fragmentation in which experience is compartmentalised (Hilgard, 1977). Dissociation of consciousness exists along a continuum, ranging from common experiences such as day dreaming and transient lapses of attention, to total amnesia. Amnesia can be defined as memory loss of an event. The experience may be so extreme, that the individual has ‘forgotten’ all or part of what has happened. Amnesia may be functional (Hilgard, 1977), i.e. adaptive in the short term, but probably maladaptive in the long term (Lazarus, 1966). A consequence of long-term amnesia may be that trauma symptoms are locked or fixed (Janet, 1889) into the psychophysiological condition at an unconscious level (Rossi, 1993; Cardeña & Nijenhuis, 2000) resulting in recurrent intrusions of the trauma.

Another consequence of traumatic dissociation is emotional numbing: an inability to feel emotions of any kind, especially those associated with feelings of intimacy, love, and affection (Feeny,
Zoellner, Fitzgibbons & Foa, 2000). Amnesia as well as emotional numbing may be considered as unconscious ways of dealing with and controlling a traumatic event (Horowitz, 1997) by dissociating memories and emotions of the event from the ‘normal’ consciousness. What is overwhelming is pushed out of the consciousness as a protection against extreme emotional impact (Classen, Koopman & Spiegel, 1993) (see figure 1, p. 36).

In the present research dissociation is conceptualised as a cognitive/affective response to an emotionally overwhelming experience, i.e. a psychological trauma.

State Dependant Memory Learning and Behaviour (SDMLB): When you are dissociated you are in an altered state of mind, which may result in an alteration of the normal mind-body encoding of experiences (van der Kolk, 1986; Rossi, 1993; Hilgard, 1997; Rossi & Cheek, 1997) due to the phenomenon of State Dependant Memory Learning and Behaviour (SDMLB) (Van der Kolk, 1986; Rossi, 1993; Hilgard, 1997; Rossi & Cheek, 1997; Nijenhuis, 2004). Theories of SDMLB claim that an individual’s psychophysiological state at the time of an experience affects what is learned and remembered from the experience and thus also how the individual acts after the experience.

SDMLB is considered to underlie dissociative reactions to extreme stress as well as subsequent experiences of revival of the trauma (van der Kolk, 1986; Rossi, 1993, Table 2, pp. 48-49 for an overview of the evolution of SDMLB theory). The phenomenon of SDMLB is connected to the theory of Encoding Specificity (Rossi, 1993; Christianson, 1997): ‘State dependent memory’ is built on a theory which states that the state of mind the person is in, when she experiences or learn something, makes it easier to remember what is learned, when she later is in the same state of mind. What we experience determines what is encoded and how it is encoded. What is encoded then determines which lead threads are effective when information is recalled. The altered state of mind caused by severe stress has been identified “as a form of spontaneous hypnosis which encodes state-bound problems of symptoms” (Rossi, 1993, p. 51). What is encoded in such a situation is what is important for survival, and what is remembered is also primarily aspects of importance for survival, which can make it difficult to recall the event as a connected whole. Furthermore, recollections of traumatic experiences will often happen unintentionally as uncontrollable intrusions, provoked by aspects reminding of the original trauma, where the person enter a similar state of mind as during the trauma.
Invasion: Recurrent intrusions or invasion of the trauma are specified in the diagnosis of ASD and PTSD as intruding images, thoughts and recurrent distress when reminded of the trauma (American Psychiatric Association, 2000).

The trauma may appear so potent that just one aspect, resembling the trauma situation, whether it is an emotional, physical, social, or cognitive aspect, may trigger all of the experience and the person is flashed back into the trauma again (Loewenstein, 1993; Rossi, 1993; Falsetti, Resnick, Dansky, Lydiard & Kilpatrick, 1995; van der Kolk & McFarlane, 1996; Rossi & Cheek, 1997).

The reason for these intrusions may be due to the phenomenon of imprinting. The term imprinting originally referred to primary critical experiences taking place concerning attachment behaviour (Bowlby, 1997; Lorenz, 2002). Today the term is also used in relation to experiences taking place in overwhelming emotional situations, e.g. a sexual assault. Imprinting in that respect refers to a process of ‘fixing in place’ the traumatic experience in the individual’s unconscious mind (Rossi & Cheek, 1997; Eimer, 2000). An ‘imprint’ implies that the person in the aftermath may experience that certain ‘triggers’ or ‘cues’ may evoke the trauma. Triggers can be internal (e.g. renewed stress, physical sensations, feelings of being rejected) or external (e.g. being alone, sexual stimuli, sensory stimuli like physical touch, smells, sounds, or lighting).

Due to the altered state of consciousness caused by the trauma the imprinted experiences may be stored in the memory as isolated fragments often outside conscious memory (amnesia) and thus also outside personal control. This is illustrated in Figure 1.
In 1940 the field physician C. S. Myers described the dissociated part after trauma as an “Emotional Personality” (EP) (Myers, 1920; van der Kolk, van der Hart & Marmor, 1996b; Van der Hart, van Dijke, van Son & Steele, 2000; Nijenhuis, 2004) storing the trauma. The trauma symptoms may be locked or fixed (Janet, 1889) into the psychophysiological condition at an unconscious level, even after the person apparently returns to her normal mode of functioning, the “Apparently Normal Personality” (ANP) (Rossi, 1993; Cardeña & Nijenhuis, 2000). This means that ANP is the part of the individual trying to lead a normal life, while EP is the part reexperiencing the trauma.

The dual representation theory: The dissociated “Emotional Personality” as Myers described has similarities to the “situationally accessible memory” system (SAM), described by Brewin and colleagues (Brewin & Holmes, 2003) in their dual representation theory. Brewin et al. differentiate between two memory systems that operate in parallel: A “verbally accessible memory” (VAM) system and a “situationally accessible memory” system (SAM).

The VAM system represents an oral and written narrative memory that is consciously accessible and can, by a voluntary conceptual processing, facilitate integration of the trauma experience by focusing on the meaning of the situation, by organising information, and placing it in a context. The SAM system contains the emotions evoked by the trauma, such as anger, fear, helplessness, horror and shame. The system also contains bodily responses to the trauma such as changes in heart rate, temperature changes and startle response. The SAM system thus contains knowledge and
impressions of the trauma, which have been encoded in an overwhelming situation (i.e. state dependant learning) and thus has been imprinted as nonverbal memory traces outside the individual’s conscious control. SAMs are ‘situationally accessible’, which means that they are triggered involuntarily by situational reminders of the trauma (encountered either in the external environment or in the internal environment of a person’s mental processes).

Brewin proposes that the SAM system underlies sensory flashbacks, nightmares, and physiologic reactivity to stimuli associated with the traumatic experience. The theory maintains that the original trauma memories are not altered in any way but remain intact (like the EP described by Myers) and may be vividly reexperienced again in the future if the person unexpectedly comes across very detailed and specific reminders of the trauma. The parallel to the theory of SDLMB (p.34) is clear.

Hyperarousal: Acute stress, implying being at a high level of emotional tension, may in itself have a damaging impact on the normal regulation of the physical condition (Herman, 1995; Krakow et al., 2001), but since rape is an invasion of the body there is a direct threat to physical integrity. The result of this invasion may be hyperarousal, which primarily is a physiological response (Christianson, 1997). One may say, “The body is primed to respond with hyperarousal” (Janoff-Bulman, 1992, p. 69). Arousal or hyperarousal mainly operates at a subconscious level, i.e. outside personal control.

Symptoms of arousal are psychological manifestations of intense fear and anxiety (Janoff-Bulman, 1992), and may be considered as learned alarms according to classical conditioning theories (Falsetti, et al., 1995; Falsetti & Resnick, 1997; Gershuny & Thayer, 1999). These theories propose that panic attacks can become a conditioned response to trauma related cues and generalise in trauma victims. It remains possible that a survivor might develop conditioned emotional responses while unconscious, which may provide the basis for intrusive thoughts, nightmares, and psychophysiologic reactivity (Brewin & Holmes, 2003). Even though an individual cannot literally remember her trauma, she knows unconsciously what has happened, and this knowledge is reflected in her reexperiencing symptoms (McNally, 2003). Looked at from the theory of SDMLB and the dual representation theory, bodily conditioned responses to a rape trauma can be described as state dependent behaviour triggered by situationally reminders of the trauma. Reexperiencing in itself
triggers general physiological arousal, which strengthens the memory trace and continued reexperiencing (van der Kolk, 1996).

Neurologically, intense emotion appears to activate the Amygdala and reduce hippocampal processing, inhibiting action (Selye, 1984; Shalev, 1997; Schore, 2001), especially in Broca’s area which is responsible for putting words to personal experiences (Rossi, 1993; van der Kolk, 1996).

**Summary:** The ASD symptoms of dissociation, invasion and hyperarousal are considered psychophysiological reactions of importance for survival occurring during or immediately after a life-threatening experience. It is proposed that the individual functions in an altered state of mind during and after a trauma of rape, which means that the experience is encoded, stored and thus also revived at subconscious non-verbal levels of functioning, hard to retrieve voluntarily.

While more ‘instinctual’ modes of reaction, as mentioned, may be the most conspicuous in the acute aftermath of a rape experience, because they have survival value, reactions in the long term also depend on the individual’s appraisal of the event itself and on experiences following the event. From a psychological point of view the invasion of the body in a rape experience can be interpreted as depriving the victim of human dignity, as removing her right to her own body and her right to possess an independent sexuality. The violation may in the long-term have serious consequences for the individual’s conception of herself, of other people, and the world in general as described in the following section.

**Cognitive and psychodynamic dimensions of trauma**

There are overlaps between psychophysiological conceptualisations of trauma and cognitive explanations. Cognition has to do with knowledge, insight and problem solving, which may be of a conscious as well as an unconscious kind (Hougaard, 2004).

Psychodynamic and cognitive processing are not clearly distinguishably either. Psychodynamic theory presupposes that psychological symptoms are rooted in the individual’s prior life story and experiences (Fonagy, 2001). A psychodynamic way of putting the consequences of a rape into perspective is to look at how prior experiences from the individual’s life are activated by the trauma and may be part of the process now of finding a meaning. Thus the distinction made here is arbitrary. The distinction is made to elucidate how a trauma may affect the individual at different levels of functioning. While the psychophysiological levels affected by trauma are considered
mostly non-verbal, cognitive and psychodynamic processing of the trauma are considered mainly as verbal and conscious processes, focusing on aspects of the trauma stored mainly in the so-called Verbally Accessible Memory system (VAM) (Brewin & Holmes, 2003).

A traumatic experience challenges the individual’s basic assumptions that underlie her expectations, behaviour, and appraisal (e.g. identity, world view, safety, trust, esteem, intimacy, power or independence) (Shalev, 1997). Cognitive and psychodynamic theoretical frames have been used in the present studies to describe the consequences of rape on the victim’s coping behaviour in the long term, on her personal well-being and on her relationships.

Coping strategies: How an individual mitigates the consequences of a rape-trauma depends to a high degree upon the strategies she employs to cope with the trauma.

Coping may be seen as the extent to which a person experiences whether sufficient resources are available or not (Antonovsky, 2000). Coping is connected to cognitive schemes, which are relatively stable cognitive structures containing and organising assumptions, beliefs, and expectations about one self, other people and the surroundings (McCann & Perlman, 1990). The coping strategies employed in a situation depends on the meaning the person attaches to the situation; meaning understood as culture in the sense of values and knowledge (Gjærum, Grøholt & Sommerschild, 2000); i.e. the person’s appraisal of the situation, her possibilities of action and her previous experiences. Most individuals share the belief of a safe and secure world (Janoff-Bulman, 1992). Faced with trauma this belief is shattered (Janoff-Bulman, 1992) and the person may feel guilty and ashamed, because there was nothing she could do to prevent the trauma from happening. Janoff-Bulman mentions three areas where the effect of victimisation is clearly shown: 1. The belief in personal invulnerability in a benevolent world, 2. The experience of the world as meaningful, and 3. The experience of oneself as worthy. Realising that cognitive schemes and coping strategies are not reliable to keep one safe may make the person feel victimised and result in development of coping strategies of avoidance to ensure survival. This emotionally focused coping (Lazarus, 1993) is, however, considered unhelpful for the majority of trauma victims (Garber & Seligman, 1980; Brewin & Holmes, 2003; Antonovsky, 2000).

Avoidance is a symptom cluster of the diagnosis of ASD and PTSD appearing as marked avoidance of stimuli that may remind of the trauma (American Psychiatric Association, 2000).
The constructive processes of the victim concerning the rape is highly influenced and modified by her interaction experiences with other people, including the experience of interaction with the perpetrator.

**Relationships**

*Regression:* Aspects connected to safety and security (Erikson, 1950; Bowlby, 1997) are conspicuous after trauma, and possibly especially after man-made traumas. The ‘regression’ occurring (Stewart, 1989; Schore, 2001) is one reason why the relational aspect becomes so important. It is suggested that confrontation with severe stress may make the adult brain regress to an infantile state (Schore, 2001), which may make the victim feel out of control and in need of other people to take care of her (Rossi & Cheek, 1997; Nijenhuis, Vanderlinden & Spinhoven, 1998; Stern, 1998). The experience of rape may result in *mental defeat*, “a state of giving up in one’s own mind all efforts to retain one’s identity as a human being with a will of one’s own” (Ehlers et al., 2000). Mental defeat goes beyond mere helplessness in attacking the person’s very identity (Janoff-Bulman, 1992; Brewin & Holmes, 2003). From an existential point of view the individual may feel that she has lost her old identity. She realises her vulnerability and may be forced to make up her mind about her own existence. The victim’s prior life story becomes important in this respect.

*Attachment:* A psychodynamic model of trauma stems from the paradigm of loss, mourning and grief (Bowlby, 1980). The victim’s experience of security and confidence in other people is shaken. Trauma is a psychological loss. Exposure to danger motivates an individual to seek protection and shelter in someone to whom she is attached (Zachrisson, 2005). Yet, it is not only the confidence in one self that is shattered by a sexual assault; the confidence in interpersonal relationships may likewise be in dissolution (Christianson, 1997; Jind, 2000), and put relationships to the test. Also interactions between the individual and society e.g. contact with authorities as the police may influence maintenance and recovery.

**Consequences for therapy**

Being exposed to a sexual assault is considered as a psychological trauma that may affect all areas of an individual’s life and all levels of functioning. A multidimensional approach thus seems to account best for understanding and description of the sequelae of a sexual assault (Shalev, 1997).
Based on the paradigm of sexual assault as a multifaceted experience a multidimensional therapeutic approach is recommended, e.g. an approach comprising non-verbal as well as verbal techniques, and which is capable of meeting the diverse therapeutic needs at the time and pace as they are presented by the individual victim. It may be important in the therapy to treat reactions in the victim to the assault itself, but also reactions to the experiences the rape victim might have in interpersonal relationships and in relation to authorities in the aftermath.

METHODS AND DATA

In this section the techniques for data collection and sampling of the studies will be introduced. The materials and the methods for data analysis will be described, and finally the validation of the research will be discussed.

Overview of studies

The three studies included in the research were conducted after attaining approval for the research from the Danish Data Protection Agency and the Scientific Ethics Committee of Copenhagen and Frederiksberg. The studies are:

Study I: Assessment of acute stress reactions in 50 women referred for psychological treatment at the Centre for Victims of Sexual Assault, Copenhagen.

Study II: A follow-up assessment of long-term reactions in 28 women, who had taken part in study I, conducted after an average time of 1.7 years post-assault (follow-up rate was 56%).

Study III: An examination of the psychotherapeutic process of 6 women, who had participated in study I and II.

Mixed methods strategy

The goal of the present research was to assess the prevalence, character and severity of traumatisation in rape victims, to understand how rape can become a traumatic event, and how the consequences of rape might be therapeutically relieved. In order to obtain this knowledge it was necessary to employ methods that make it possible to examine reactions to rape from different
angles and at different levels of analysis. To understand the complexity of reactions and experiences of rape, using more than one method would make it possible to obtain a more complete picture of rape-related problems (Morse, 2003) and hence to be able to set up a psychological treatment to mitigate problems post-rape. Since a purely quantitative or qualitative approach would not sufficiently capture the complexity of the problem, using a combination of quantitative and qualitative strategies i.e. a mixed methods strategy (Tashakkori & Teddlie, 2003) was chosen in order to strengthen the research (Onwuegbuzie & Teddlie, 2003).

In mixed methods each approach provides an incomplete picture (Johnson & Turner, 2003). The concept of “mixed method” is sometimes used synonymous to the concept of “triangulation.” Triangulation is collecting information from a diverse range of individuals and settings as well as using a variety of methods (Rothbaum, Foa, Riggs, Murduch and Walsh, 1992). Mixed methods are suggested as a substitution for the concept of triangulation because the word triangulation is “overused” (Sandalowski, 2003): “Having too much meaning the word triangulation has no meaning at all.“ - “It appears as a “neartalismanic method” (Sandelowski, 2003, p. 328).

The fundamental principle of mixed methods research is that methods should be mixed in a way that has complementary strengths and non-overlapping weaknesses (Johnson & Turner, 2003). The researcher has kept this principle in mind during the research process of elucidating the diverse aspects of a rape experience.

**Quantitative and qualitative approaches**

Quantitative as well as qualitative approaches and techniques have been used in the present research both in collecting and analysing data.

“The term quantitative implies something that can be quantified or measured, and in that sense it might be applied to those things that involve counting as numerical data and the use of some statistical procedures.

The term qualitative implies making an assessment or judgment that involves interpretation. It might therefore be applied to both certain types of data (those that involve making judgments) and interpretative analysis, with the latter typically involving text or other non-numerical material but potentially also numerical data or statistical output” (Bazeley, 2003; pp.387-388).
In the present studies a quantitative data collection preceded qualitative data collection. The intent with this approach was to explore variables of the rape situation first (i.e. the data base registered information) and then include qualitative information to supplement the quantitative data and explore the rape experience in more depth.

To understand how rape can be a traumatic event inevitably involves research into meanings of the rape for the victims themselves, i.e. how the victims interpret the process, and which meaning they assign to it. The issue of meaning is more directly addressed through qualitative than quantitative research.

Employment of a mixed method technique in the present research has made it possible to elucidate a rape experience from different angles and at different levels of conceptualisation, intended to be complementary. Three perspectives have been employed:

1. An assessment of traumatisation by using standardised scales and an estimation of predictive variables for development of trauma reactions. In the present research traumatisation was assessed according to the Diagnostic and Statistical Manual-IV (DSM-IV) diagnosis of Acute Stress Disorder (ASD) and Posttraumatic Stress Disorder (PTSD) (American Psychiatric Association, 2000). The advantage of using standardised instruments and deduct influential variables is that it provides a basis for statistical analysis and comparison of the results with findings from other studies. Its disadvantage is that it decontextualises the traumatic event into bits and pieces (Dahl, 2003). Assessment of ASD and PTSD is described in Article I and II of the present dissertation.

2. In order to extend the understanding of the psychological impact of the trauma of rape the Copenhagen Rape Experience Interview (CREI) was elaborated and employed in the present research (Articles II and III). It contains open- and closed-ended questions about the individual victim’s experience of the rape and its consequences.

3. To attain an understanding of a rape experience as a whole entity a description and analysis of the therapeutic process was included. By focusing on the victim’s process of recovery a better understanding of her experience and its consequences can be achieved and the understanding of the traumatic elements is enhanced (Dahl, 2003). The psychological process is described in Article III.
**Participants**

The participants included in the three studies were recruited from the whole sample of enquiries at CVS in 2001-2004 (N=994). Out of these 994 victims, 446 (44.9%) were referred to psychological treatment at CVS. The participants in the present studies were limited to female victims of rape or attempted rape, which had been referred to psychological treatment. In order to get an overview of the group of victims accepting psychological treatment, no other specific selection criteria were applied.

The number of subjects varied in the different studies, depending on data collection modes, time frames for the project, and the dropout rate.

Besides age, the studies included background characteristics and demographic data of the victims, which were: prior sexual traumas, prior psychiatric treatment, chronic illness, alcohol/drugs abuse, and occupation. These characteristics will be described in the three articles.

**The core group**
The initial study group was 50 women consecutively admitted for psychological treatment at CVS from May 2003 to April 2004. These 50 women participated in the study of assessment of acute reactions (Article I). The age range was 15-44 years.

**The follow-up group**
The 28 participants in the follow-up study conducted in 2005 (Article II), were all recruited from the 50 participants of the initial study. The 28 participants (56% of the core group) in the follow-up study were between 15-41 years of age.

**The case study group**
The six cases of the psychological treatment study were between 15 and 29 years old. The cases were selected among the 28 participants of the follow-up study to represent varied demographic characteristics and variables related to the assault, which were also seen in other rape victims presenting at CVS (Center for Voldtægtsofre, 2004).

The six persons reported a number of recurrent problematic experiences in relation to the rape experience, even though their situations were very different\(^3\). Inclusion of six cases were considered

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\(^3\) The particular characteristics of the individual cases will be described in further detail in Article III.
as being a large enough number to ensure that sufficient different aspects of the psychological treatment process were represented, and thus also large enough to allow the researcher to draw some general conclusions from the study. More than six cases could produce too much information for a thorough analysis (Kvale, 2004). The six cases included were women who had participated in the studies of acute and long-term reactions, who had received psychological treatment by the researcher at CVS, who were of different ages, who had been exposed to different rape situations, who had different family constellations, and who had had different experiences in the aftermath. This was judged to be a sufficiently solid foundation for an analysis of the various elements of a therapeutic process.

**The dropout group**
Twenty-two women (44% of the core group) did not come for the follow-up study. Of the initial 50 participants one had died and two could not be reached. By telephone contact six reported that they did not want to take part in the follow-up study because they were afraid of having the assault raked up. Out of these, three women felt quite well and the other three women reported that they were still rather affected by the rape experience.

**Ethics**

The data based information concerning the participants in the present research has been coded with numbers to avoid the inclusion of personal identifiers. Identifiable elements have also been removed from the reports.

At the follow-up contact each participant has given her informed consent under subject anonymity by signing an agreement of participation (Appendix F, p. 202).

Great importance was attached to minimising pressure on participants, for which reason the data collection of acute reactions took place as part of the psychological treatment. Assessment of Acute Stress Disorder is made initially in the psychological contact with victims as a frequently conducted procedure at CVS, and the assessment is used as psychoeducational information for the victims indicating common reactions to trauma and as a guideline for the psychological treatment. The ASD assessment is considered therapeutic, and most victims express relief by learning that the reactions they have are ‘normal’ in persons experiencing trauma. The data for the studies were thus provided in a way paying as much regard as possible to the vulnerability of the participants.
The follow-up interview represents a risk of retraumatisation. To minimise this risk each participant was offered a contact with the researcher after the interview. All victims who receive psychological treatment at CVS are offered renewed contact when needed after the treatment has ended, and quite a few make use of this opportunity. The fact that the researcher and the therapist was the same person might have impaired autonomous decision-makings in relation to participation. Therefore the victims who were invited to the follow-up interview were offered a possibility of calling the researcher, if they needed further information before making a decision whether to participate or not. Researcher bias will be discussed in the validity section below. The participants in the studies have been treated in accordance with the ethical standards and confidentiality requirements of the Danish Psychological Association (Dansk Psykologforening, 2000).

**Methods for data collection**

Different sources of data information have been employed in the studies: empirical data as well as theoretical data. Most of the empirical data collected in the studies came from the participants themselves through two assessment interviews. The first was conducted during the first or second session with the psychologist, and was an assessment of the victim’s acute state according to the diagnosis of ASD.

The second assessment was made 1 year and 7 months (in average) after the assault as a follow-up interview on trauma responses according to the diagnosis of PTSD supplemented by an interview concerning individual conceptualisations of the assault, complaints after the assault, and changes in the individual’s life situation and perspective in general. The interview form was chosen in the studies of assessment of acute and long-term responses to a sexual assault. One reason for this was a view that an interview is more personal than a questionnaire and in that way the trust, which hopefully exists between the participants and the interviewer, might induce the respondent to be more truthful in her responses. The standardised interviews employed in the studies have the same advantages as questionnaires in relation to statistical analysis (Burns & Bush, 2000). Still, qualitative interviews can be prone to errors, and this dilemma will be addressed below when discussing the validity and reliability of the data.
Since 2001 a registration form for each enquiry at CVS has been filled in. This registration form has continuously been transferred to a numeric database created in SPSS for Windows (version 11.0). The database-registered information on all victims enquiring at CVS in 2001-2004 (N = 994) has been employed to make comparisons between those who attended psychological treatment and those, who did not, and also between those who took part in the studies and those who did not to see if the participants in the present study were representative for enquiries to CVS.

The secondary data sources were the researcher’s psychological therapy records from CVS and academic literature about rape and trauma in the form of articles and books.

The primary data collection will be explained first and the secondary data collection next, followed by a section on data analysis and a discussion of the reliability and validity of the research.

An overview of methods and data of the present research is presented in Table 1.

<table>
<thead>
<tr>
<th>TOPICS OF STUDY</th>
<th>STUDIES</th>
<th>STUDY METHODS</th>
<th>VARIABLES AND FACTORS</th>
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</table>
| Acute reactions to sexual assault| Study I                                      | Statistical analysis of quantitative data from the general database of CVS 2001-2004 (N=994), and a separately erected database (n=50). Interviews using ASDS (Acute Stress Disorder Scale) | Age  
Intake of alcohol/drugs before assault  
Resistance during assault  
Type of assault (rape/attempted rape)  
Violence/threats of violence  
Relationship with perpetrator |
| Long-term consequences of sexual assault | Study II                                     | Statistical analysis of quantitative data from a separate database (also used in Study I). Interviews using PDS (Post traumatic Diagnostic Scale) and Copenhagen Rape Experience Interview (CREI) | Age  
Intake of alcohol/drugs before assault  
Resistance during assault  
Type of assault (rape/attempted rape)  
Violence/threats of violence  
Relationship with perpetrator  
Conceptualisation of assault  
Psychophysiological issues  
Relational issues  
Strains before and after assault |
| Psychotherapeutic treatment after sexual assault | Study III                                    | Clinical qualitative evaluation of the therapeutic process systematised and condensed using the Systematic Text Condensation (SCT) | Psychophysiological issues  
Relational issues  
Strains before and after assault |

Primary data collection
Background characteristics and demographic data of the participants of the present research were drawn from the database containing information on all enquiries to CVS. The information collected
Instruments used in assessments

**Acute Stress Disorder Scale (ASDS) (Article I).**

The ASDS is an instrument developed to assess responses occurring within one month following an extreme traumatic event. The ASDS has been validated against DSM-IV criteria for Acute Stress Disorder (ASD) (Bryant, Harvey, Dang & Sackville, 1998; Bryant & Harvey, 2002) (Appendix A, p.186).

The ASDS consists of nineteen questions and is divided into four clusters of symptoms concerning cognitive, emotional and psychophysical reactions. The symptom clusters are: *dissociation* (five items), *invasion* (four items), *avoidance* (four items), and symptoms of *hyperarousal* and fear (six items) (Bryant et al., 1998; American Psychiatric Association, 2000). Scores are from 1-5: 1 (not at all), 2 (mildly), 3 (medium), 4 (quite a bit), 5 (very much); total scores are from 19-95. Criteria of ASD are a dissociation score ≥ 9 (and a score of more than 1 in at least three out of the five symptom items of dissociation), and a total score ≥ 28 for responses on the other three cluster categories (invasion, avoidance, and hyperarousal) (Bryant & Harvey, 2002).

**Acute Stress Disorder and Acute Stress Reaction**

At CVS a registration form is filled out for each enquiry, consisting of parts covering information on the assault and the medical history plus data concerning sociodemographic- and psychological issues. The medical admission ward assesses all enquiries at the first visit according to fulfilment of the diagnosis of Acute Stress Reaction (ASR) (WHO, 1994). This registration is highly biased, since victims are not asked about their responses, that is, the registration is based solely on the observer’s assessment. ASR is constructed to assess normal reactions within the first two days following a psychological trauma. Since most enquiries at CVS take place between one to three days post-assault, the time limit of the ASR constitutes a serious bias in using the diagnosis. The registration of psychological reactions using the ASR diagnosis is thus not reliable and unsuitable for research purposes. Therefore a new self-reported assessment was made in the present research employing a different diagnosis, namely the Acute Stress Disorder (ASD) (American Psychiatric
Association, 2000). A comparison between the assessment of ASR and ASD in the 50 participants in the present study confirmed that the ASR screening is unreliable: There was no relation found between ASR registered symptoms and self-reports of ASD symptoms in the 50 participants of the initial study of this research (Appendix E, p.201).

The Posttraumatic Diagnostic Scale (PDS) (Article II)
The PDS is a brief screening and diagnostic instrument designed to assess the presence and severity of PTSD based on the DSM-IV (Dancu, Riggs, Hearst-Ikedo, Shoyer & Foa, 1996; American Psychiatric Association, 2000). The scale has demonstrated high internal consistency and test-reliability; it shows high agreement with the Structured Clinical Interview for DSM-IV, and a good sensitivity and specificity (Nishith, Griffin & Poth, 2002).

One of the reasons for choosing this scale was that it is validated with rape victims (Dancu et al., 1996; Foa, Cashman, Jaycox & Perry, 1997). The PDS scale consists of seventeen items distributed on the three PTSD-criteria: reexperiencing (five items), avoidance (seven items), and arousal (five items) (Dancu et al., 1996). Each symptom is rated on a 4-point scale from 0-3: 0 (‘never’ or ‘only once in a while’), 1 (‘once a week or less’/‘sometimes’), 2 (‘two to four times a week’/‘half of the time’), 3 (‘five times a week or more’/‘almost always’). Total scores are from 0-51 points. To attain a diagnosis of PTSD demands endorsement (rating of 1 or higher) of at least one reexperiencing symptom, three avoidance symptoms and two arousal symptoms within the last month (Foa et al., 1997) (Appendix B, p.191).

ASDS and PDS are standardised tests. They are structured and closed-ended with rating scales. They are instruments with a written protocol used in a standard way with all respondents (Johnson & Turner, 2003). The interviewer simply reads the questions and records the answers. A major strength in using standardised tests is that they allow comparability of measures across research populations (Johnson & Turner, 2003). A weakness is, however, that standardised tests do not always fit individual reactions, or catch the diversity of possible reactions to e.g. a traumatic event as rape. To supplement the quantitative data and study reactions to a sexual assault in more detail The Copenhagen Rape Experience Interview (CREI) was elaborated.
CREI - An intramethod instrument (Articles II and III)

Methods that are not clearly either qualitative or quantitative are termed intramethods (Johnson & Turner, 2003).

CREI employed in studies II and III constitutes such a mixed instrument (Appendix C, p. 195). The questions of the CREI were designed to reflect individual aspects and views on the assault. The purpose of including the CREI was to attain an understanding of sexual assault in more detail and in a broader context than obtainable through a diagnostic assessment.

The CREI consists of 36 open- and closed-ended questions concerning the assault itself, conditions following the assault, and additional strains following the assault. Questions concerning individual reactions comprise reports on physical problems including changes in eating habits, thoughts of or attempts of self-mutilation, changes in alcohol and/or medicine or drugs intake, and changes of attitudes towards oneself and others. The advantage of open-ended items is that the interviewees provide the answers in their own words, so that you get a clearer picture of consequences of a rape experience for the individual victim.

An interview protocol was structured in order to conduct the interviews in a deductive manner. The phrasing of the questions was the same for all interviewees, but the interviewer was allowed to explain questions in more detail if necessary and to change the order of the questions to make the interview more fluent.

The main purpose with collecting the empirical mixed data of the CREI has been to support and supplement the numeric data collected to gain insight into the individual rape victim’s experience and perception of the sexual assault. This insight is important in evaluating whether the psychological treatment is organised according to the expectations and experiences of the victims. Information concerning individual needs for psychological treatment was attained by the use of open-ended questions in the CREI concerning experiences of the treatment offered at CVS. Answers to these questions were included in article III.

Secondary data collection
In the present research secondary data consists of data collected from the researcher’s psychological therapy records as well data collected from studies of literature.
This is a little different from what is usually included under the heading of secondary data defined as “data .. originally recorded… or collected at an earlier time by a different person from the current researcher, often for an entirely different purpose ….” (Johnson & Turner, 2003).

**Psychological records**
The data collected specifically for exploration and description of the psychological therapy process (Article III) was the researcher’s psychological records based on themes and reactions registered after therapy sessions. The case study method was the approach chosen because of its usefulness in analysing the dynamic whole of a person and in exploring a therapeutic process over time (Launsø & Rieper, 2000; Thagaard, 2003; Fog, 2004; Camic, Rhodes & Yardley, 2004; Hougaard, 2004; Kvale, 2004a).

**Literature data**
The data collected from literature consists of a compilation of academic articles and books pertaining to themes or subjects related to the topic of rape and other types of sexual assault, to the topic of psychological trauma and stress more broadly; and to responses, reactions and recovery after trauma and sexual assault. Initially after her employment in CVS in 2000 the researcher read Judith H. Herman’s book “Trauma and Recovery” (1992). This book was a link to key-researchers, mainly American, concerning rape and trauma such as Edna B. Foa, A. W. Burgess, L. L. Holmstrom, R. R. Hazelwood, B. O. Rothbaum, M. P. Koss, P. A. Resick, H. S. Resnick, D.G. Kilpatrick, M. J. Horowitz, and Bessel van der Kolk. In relation to psychotherapy D. S. Rose’s writings on psychodynamic therapy with rape victims were especially inspiring. In Scandinavia the most important inspiration for the present studies has been the Norwegian psychiatrist Solveig Dahl’s doctoral dissertation “Rape – A Hazard to Health” (1993). Author names have thus frequently been used in information retrieval. The retrieval of literature for the studies can be described as a dynamic process, gradually developing depending on what was of topical interest during the research process. The library databases employed in the present research has primarily been www.PubMed.com, www.mentalhealth.com, www.google scholar.com, www.PsycInfo.com, www.psychlit.com, and Web of Science, via link-to-link-search, and via reference lists of the texts found in the databases. The search was made via keywords in English relevant for each of the three studies included. The main keywords used in all three studies have been rape, rape victims, sexual
assault, sexual abuse, sexual harassment, psychological trauma, relational trauma, traumatic stress, psychological stress, and stress-related disorders. In study I the specific keywords have been linked with acute, Acute Stress Disorder, ASD and words concerning examined variables in the study: age, alcohol, drugs, resistance, violence, amnesia, dissociation, arousal, coping, flashback, and others. The existing literature and research about acute reactions to sexual assault is scarce, mostly produced from acute reactions to other traumas than rape, e.g. traffic accidents (Bryant & Harvey, 2003). Concerning literature on posttraumatic stress linked to the diagnosis of PTSD, on the other hand, much more literature is available, also concerning sexual assault. The same combination of words used in information retrieval in study I has been used in study II, but here the keywords have mainly been combined with Posttraumatic Stress Disorder and PTSD. In study II the keywords have also been combined with words as network support, physical health, social health, sexuality, predictors, risk factors, self-mutilation, anxiety, depression, grief, eating disorders, sleeping disorders, shame, guilt. In study III the main keywords have been combined with words concerning psychological treatment such as crisis intervention, acute intervention, early intervention, survivor therapy, mind-body therapy, hypnosis, survivors, resilience, attachment, recovery.

Summary
This section explained the data collection methods for the research, described as a mixed method technique starting with collection of quantitative data to put the research into perspective and moving into qualitative techniques to explore reactions to rape in more detail and from the perspective of the individual victim.

Data analysis and interpretation
As mentioned above different approaches to data collection have been employed in the three sequential studies of the research. The data collection method was referred to as a mixed method. In order to enhance the quality of the data interpretation, the research purpose for the present studies has been to retrieve as much meaning as possible from the collected data. Different strategies and techniques for analysing the data have therefore been employed. A mixed methods data analysis has been conducted, because it makes it possible to use different perspectives in analysing the data. Quantitative statistical methods as well as interpretive qualitative methods have been employed.
The analysis has taken place in a sequence of phases before all data were collected (Onwuegbuzie & Teddlie, 2003).

A quantitative variable-oriented as well as a qualitative case-oriented analysis has been conducted. In variable oriented approaches the building blocks are variables and their intercorrelations (Onwuegbuzie & Teddlie, 2003). In the present studies the variables have been symptom clusters of ASD and PTSD, the six variables selected assuming to influence posttraumatic stress plus variables included in the CREI. A case-oriented approach has been employed in the analysis of the six cases described in Article III because this approach makes it possible to consider “the case as a whole entity, looking at configurations, associations, causes, and effects within the case – and only then turns to comparative analysis of a (usually) limited number of cases” (Onwuegbuzie & Teddlie, 2003, p.357).

Data reduction
“Reducing the data sharpens, sorts, focuses, discards, and organises data in such a way that ‘final’ conclusions can be drawn and verified” (Onwuegbuzie & Teddlie, 2003, p.363). How this reduction has been conducted in the present research will be described below when the concrete data analysis process is reviewed.

Data transformation
The objective of conducting data transformation in the present research has been to extract as much meaning as possible from the data. Data transformation means that data are “quantitised “ and/or “qualitised” ((Teddlie & Tashakkori, 2003). An example of “qualitising” (i.e. transformation of quantitative numerical data into verbal data that can be analysed qualitatively) was, how a comparison of responses to the scales assessing symptoms of ASD and PTSD helped in distinguishing between victims under the influence of alcohol or drugs during the assault and victims not under the influence of alcohol or drugs (Articles I and II). The term “quantitising” stands for conversion of qualitative data into numerical codes that can be represented statistically (Onwuegbuzie & Teddlie, 2003). Such a “quantitative translation” (Sandalowski, 2003) was conducted with answers to the CREI (described below).
Quantitative data analysis (Articles I and II)
From the ‘general’ database of CVS containing data of all enquiries at CVS in 2001-2004 (N = 994) was drawn the information relevant for the present research. The general database covers extensive information on the assault, on the medical history, examination and treatment, on demographic data, on personal background data and social issues, and information on establishment of psychosocial contact. The information from the general database is much more comprehensive and detailed, than what was needed for the present research, especially concerning medical information. Information for the present research drawn from the database on all enquiries at CVS was information on whether psychological contact at CVS was established or not, information on the assault (rape/attempted rape), physical violence or threats of violence from perpetrator, relationship between victim and perpetrator before the assault, intake of alcohol/drugs before the assault, demographic data (land of origin, age, occupation), personal background data (prior sexual assault, prior psychiatric treatment, chronic illness and abuse of alcohol/drugs). The choice of the information drawn was made on an assumption about what might be possible predictors of the severity of posttraumatic stress. The information drawn from the general database was recoded and transferred to a separate database. Some data were transferred directly from the general database. Other data, e.g. concerning detailed information on the assault have been added up in fewer categories before they were transferred to the separate database. Scores of the responses to the assessment instruments of ASDS, PDS, and CREI were transferred to the separate database. The answers from the CREI were designed into 36 variables in SPSS, dichotomised into a yes/no registration (Nielsen & Kreiner, 1999). This “quantitising” (Teddlie & Tashakkori, 2003) of the mixed data of CREI into numeric codes made a statistical comparative analysis possible with the data from ASDS and PDS. The reverse of “quantitising” is named “qualitising”, and the conduction of this technique will be described in the section of ‘qualitative data analysis’.

The separate database was used in drawing data for the studies of Articles I and II, and part of Article III.

The Pearson Chi-Square test was used to test differences in proportions between groups (Nielsen & Kreiner, 1999; Burns & Bush, 2000). Since the cell sizes were small, Fisher’s exact test was also used (Rosenthal, Rosnow & Rubin, 2000).
As the continuous variables age and mean scores of different items and clustered symptoms were not normally distributed, the Mann-Whitney test was used to test whether age and mean scores were different between two groups (Burns & Bush, 2000). When more than two groups were compared (age groups), Kruskall-Wallis test was used. P-values of ≤ 0.050 were for the present studies considered statistically significant.

Associations between scores on the three instruments were examined: The ASDS, the PDS and the CREI, as well as associations among the single items of each of the instruments. The scores of each instrument were examined in relation to six variables assumed to influence responses to a sexual assault: age, intake of alcohol and/or drugs before the assault, resistance, rape/attempted rape, physical violence/threats of violence, and relationship with perpetrator.

**Qualitative data analysis (Article III)**

A goal of qualitative research is “to capture the voice of the persons being studied” (Onwuegbuzie & Teddlie, 2003, p. 369).

The mixed analysis conducted in the present research was made with the aim of describing reactions in rape victims from different angles to enhance the quality of data interpretation (Onwuegbuzie & Teddlie, 2003).

Since the present studies deal with human reactions and relationships, a constructivist/phenomenological approach in data analysis has been employed (Hougaard, 2004). The paradigm of “constructivism” is that investigations must employ empathic understanding by including the interests and values of those being studied (Tashakkori & Teddlie, 2003). Constructivism supports qualitative methods. When undertaking analysis of phenomena as well as themes, inferences are made from the sample of words collected from the participants to the “truth space” of the group or the phenomenon studied, “hoping that the sample of the participants’ voices are representative of the truth space” (Onwuegbuzie & Teddlie, 2003, p. 369). A way of testing the representativeness is to employ mixed methods in analysis of collected data, i.e. to view the same phenomenon from different angles and to transform data to make comparisons between quantitatively and qualitatively collected information. To compare the reactions of participants on the different variables included, the quantitative data collected on assessment of ASD and PTSD was reduced. The reduction was made by clustering the data into subgroups and qualitising the information (Tashakkori & Teddlie, 2003) by conducting descriptive summaries that were analysed qualitatively.
Analysis of psychological records

The case study included in the research was based on data from psychological records containing summaries of therapeutic dialogues. Summaries of the records were made after the first month of therapy, after three months and lastly at the therapeutic follow-up contact with the researcher. The material from the psychological records was categorised for each case and also across the six cases according to the theoretical and conceptual framework of the research, i.e. focusing on psychophysiological, cognitive, and psychodynamic elements and themes as they occurred in the therapies. A ‘meaning condensation’ technique (Charmaz, 2000; Launsø & Rieper, 2000; Smith & Kelly, 2001; Giorgi & Giorgi, 2004; Kvale, 2004) was applied to reduce the content of the psychological records into shorter, more concise units. The objective of the case study was to develop in depth knowledge about rape victims’ reactions and therapeutic needs and to obtain this objective, A. P. Giorgi’s Systematic Text Condensation (STC) method (Giorgi & Giorgi, 2004) was found suitable. The STC is developed to obtain knowledge about a subject’s experiences, meanings etc. within a specific field (Giorgi & Giorgi, 2004). The following four steps were conducted in the process of condensation of the six therapy records: 1. Read for a sense of the whole to attain an overall sense of the material to sort out themes. 2. Establishing meaning units by rereading the descriptions and organising elements and issues as a first step in reducing the material. 3. Transformation of meaning units into the preplanned categories selected from the researcher’s professional perspective in relation to the aim of the therapy. 4. Recontextualisation, which means to link the selected themes and issues into descriptions of the individual’s therapeutic process.

Analysis of literature data

The literature included in the research was read with the intention of 1) identifying themes or subjects related to the topic of rape and to the present research, 2) summarising previous investigations, 3) identifying similarities with and differences from the results of other studies and the present study, and 4) suggesting new initiatives in practice and research.

Reliability and validity

In the present research the terms reliability and validity are understood as follows: Reliability refers to the degree to which a measurement or observation accurately reflects the attribute or
phenomenon; that is: Do repeated measurements or observations of the same phenomenon or attribute produce consistent results from one time to the next? (Hunter & Brewer, 2003; Tashakkori & Teddlie, 2003). Validity refers to the question of whether or not one’s measurement or observation of a phenomenon is true; that is: Does it represent what it is expected to measure or represent? (Hunter & Brewer, 2003; Maxwell & Loomis, 2003). Reliability emphasises the repeated use of a single measurement or observation, while validity implies different measurements or observations (Hunter & Brewer, 2003).

Valid research means trustworthy research (Onwuegbuzie & Teddlie, 2003), which is defensible. It is common to differentiate between internal validity and external validity. Internal validity means that the results of the research within the given frame of reference is trustworthy and can be replicated; that is to say that the same results would be obtained by repeating the research (Johnson & Turner, 2003; Karpatschof, 2006). External validity demands that the results of a study are trustworthy also outside the given frame of reference and can be generalised to and across populations, settings and times (Maxwell & Loomis, 2003; Karpatschof, 2006).

Usually the design of a study, the data collection, the data analysis, interpretation and presentation of results are influenced by the person, who conducts the study (Karpatscof, 2006), especially in qualitative research. This also applies to the present studies. The researcher’s biases affect the research and thus also the reliability and validity of the results.

Several biases, i.e. sources of error, are found in the present research related to the researcher, and thus also to the design, the data collection, the setting and sampling, and to the subjects selected for the research.

Researcher bias: The researcher’s mixture of roles (researcher, psychologist, therapist for the subjects in the research, and being a woman with female victims) has implied an alternation between what can be defined as a participatory and a non-participatory research role (Johnson & Turner, 2003) depending on the kind of data collected, the instruments employed for collecting data and the methods applied in data analysis.

The researcher’s employment at the CVS has provided her with an insider approach to the research on rape victims, as she has had the opportunity of getting insight into diverse aspects concerning examination and treatment of rape victims. Furthermore she has had direct access to medical as well
as psychological material from the database and records at CVS, which have been used to seek information and collect data. Thus an employment at the CVS has been a clear advantage in collecting data for the research.

Nevertheless, the researcher’s being part of a special cultural context, i.e. the CVS, has implied a selective perception when selecting the focus of the research, when describing the reactions in the women and analysing the material, perhaps in some respects to a Rosenthal-effect degree. The Rosenthal-effect refers to how the researcher’s expectations may direct the behaviour of the persons studied and thus also the study results (Karpatschof, 2006).

The focus areas of the studies were highly influenced by the researcher’s practical experiences as a therapist for rape victims, and her experience was that the traumatic aspects of the experience were more problematic to most rape victims than the sexual aspects. Thus the scope of the research was narrowed down to include issues in relation to rape as a trauma, while the sexual aspects of the event were only peripherally examined in the CREI. Focusing on sexual aspects was considered to be too narrow for the scope of the research. Besides, it would not lead to a valid investigation of the existing problems, as the conclusions might be culturally specific to a Danish population rather than general conclusions about reactions to rape. This does not mean that the subject of sexual aspects is not relevant, and therefore the issue will be mentioned in the articles included.

The researcher’s contact with the subjects prior to the studies may have implied an over-identification with the group and if so the interpretive validity of the research has possibly been low, especially concerning the qualitative data. The degree of interpretive validity, i.e. the reliability of measurements or interpretations, could have been tested by repetition by another person than the researcher, but this has not been possible within the given frames of the research. To minimise researcher biases standardised measure instruments have been included, and the follow-up interview was conducted by an interviewer, whom the subjects had not met before. A comparison of the results with the results of other studies was also a way of trying to strengthen reliability and validity.

*Design bias:* A serious bias of the design was that the follow-up interview was conducted at different time-intervals from the assault for the participants. Personal history and maturation since
the trauma had influenced reactions and more so the longer the time passed since the event. Due to
the time and resources available it was not possible to avoid this bias.

**Data collection bias:** In order to obtain in-depth information the interview-form was selected for
data collection. Biases of interviews are that they are difficult to replicate, and researcher effects
are of greater importance than e.g. in questionnaires.
The instruments employed were not standardised in a Danish population. To diminish this bias a
“back translation” (American Psychological Association, 2002) method was employed, in which the
questions of the scales were translated from English into Danish language by the researcher and
then back into English by a person skilled in English language, who had no knowledge of the
instruments employed. This back translation was made to ensure that the translation was equivalent
enough to make the scores comparable with scores of other studies.
Psychological records were employed in the case study on psychological treatment. The aim of the
case study was to examine the process of recovery viewed from the perspective of the individual
victim. The psychological records were secondary data not kept specifically for collection of data
for the present research. The reports were incomplete and depending on themes and issues
appearing in the individual therapeutic process. Besides, reports were selectively recorded based
upon what, from the researcher’s point of view, was seen as relevant for the intervention process.
Although a process study as the case study included in the present research may complicate
comparisons with other studies (Mertens, 2003; Hougaard, 2004) it may be suitable in capturing the
complexity of a process of recovery and in that way be a way of collecting important information
on rape victims’ reactions of relevance for adjustment of the therapeutic process.

**Setting bias:** The research took place at Copenhagen University Hospital, where the subjects had
been treated following the assault. Being at the hospital again influenced some of the subjects’
responses, as well as the interviews themselves concerning rape-related problems. Also
characteristics of the interviewers and the relation between interviewer and interviewees influenced
results. The relationship between the subjects and the researcher as a therapist and as a woman was
a bias, and the fact that the interviewer conducting the follow-up interview was unknown to the
subjects, was younger than the researcher etc. also had an effect.
**Sampling bias:** Subjects were psychologically treated victims enquiring at CVS and no control group was included. This was not an ideal composition, but the best possible with the time and resources available. The selection of participants seemed justified, since also information on non-treated victims at CVS was included from the data based registration of all enquiries.

**Subject bias:** Validity problems both in collection and analysis of data were related to the composition of participants in different ways: The participants’ behaviour and responses were, among other things, affected by reminders of the trauma in the interview situation, by the contact with the interviewer, by considerations of how they would like to present themselves, and by their ideas of what was expected from them in the situation. The interaction between participants and researcher in an interview may on the other hand increase the authenticity of the reports given (Hougaard, 2004), and thus facilitate the application of study results in practice.

**Reliability and validity?**

The aim of conducting the studies of the present research was to examine reactions to a rape experience thoroughly to obtain a comprehensive knowledge of the consequences for the victims. The researcher’s assumption based on her experience as a therapist for rape victims was that rape might have an impact on all aspects of an individual’s life. What has happened in the individual’s life prior to the assault as well as what happens after the assault may influence reactions and the process of recovery. Therefore it was decided to broaden the scope of the examination of reactions to rape by including a number of variables assumed to influence reactions for a comparison among the subjects of the studies. To pursue the end of a thorough investigation and elucidate the diversity of a rape experience it was considered important to collect measurable data for comparisons as well as information on the victims’ own expressions, meanings and attitudes to the event. To achieve the aim of a comprehensive and in-depth understanding and knowledge of a rape experience mixed methods strategies and techniques have been employed in data collection and analysis. Employment of mixed methods in analysis of the collected data was a way of trying to increase the representativeness of the results (Onwuegbuzie & Teddlie, 2003), i.e. to view reactions to sexual assault from different angles and to transform data to make comparisons between quantitatively and qualitatively collected information.
The research is, however, limited in several respects: It is limited and biased in being too comprehensive with too many variables at play so that a main thread may be difficult to follow. A more focused study of specific aspects and themes could have brought forth more distinct and precise information, and it might have made it easier to follow the thread of the studies in moving from a larger sample to a few cases and from standardised assessments of reactions to a rape trauma to the voices of the victims themselves.

There are strengths and weaknesses in the researcher’s diverse relationships with the subjects of the studies. She is employed at the hospital where the victims have sought help after the assault and for most of them she has been their therapist at CVS. The strength of this versatile role was that the researcher had experience in dealing with victims of rape. Based on her experience she had ideas of what could be important points of focus in the studies, and also of how to build a confident contact during the interview to get as authentic information as possible from the participants. The weaknesses were that the researcher’s different roles could have narrowed her perspective. There was a risk of selective perception, because the researcher as a participant herself in parts of the studies could have over-identified with the subjects. Added to this, the psychological records employed as data in the case-study (Article III) were the researcher’s own therapy records. The records had been selectively recorded, which limits the interpretive validity of the study.

REFERENCES


ARTICLE I

Sexual Assault, Acute Stress Disorder and Influential Variables

Annalise Rust

Abstract

Prevalence and severity of Acute Stress Disorder (ASD) were assessed in 50 women aged 15-44 years presenting at the Centre for Victims of Sexual Assault, Copenhagen, after exposure to rape or attempted rape. Associations between ASD and six variables were examined: Age, intake of alcohol/drugs, resistance, type of assault, violence or threats of violence, relationship between victim and perpetrator.

Results: All criteria for ASD were met by 36% of the women and 88% met all criteria except criterion H. Fifty-four percent of the participants had been heavily influenced by alcohol and/or drugs during the assault. An association ($p=\leq 0.050$) was found between age and ASD: Victims $<25$ years of age had a higher prevalence of ASD than victims $\geq 25$ years of age. Victims under the influence of alcohol and/or drugs during the assault had lower scores of ASD than victims not under the influence of alcohol/drugs.

It is suggested that the ASD diagnosis is not adequate in assessment of the complex acute reactions to a sexual assault.

Key words: Sexual assault; Acute Stress Disorder; intake of alcohol/drugs; amnesia; young age.

SEXUAL ASSAULT – A TRAUMATIC EXPERIENCE

The aim of the present study was to assess the prevalence, character and severity of acute responses in female victims of rape and attempted rape according to the diagnosis of Acute Stress Disorder (ASD) (American Psychiatric Association, 2000). The objective was also to examine the influence of factors other than the assault on development of ASD responses in the victims.
Rape is defined as an act of non-consensual sexual penetration (oral, anal, or vaginal). If the act does not lead to penetration it is defined as attempted rape. The concepts assault and sexual assault are used synonymously for rape and attempted rape in the present paper.

Rape and attempted rape are considered subcategories of psychological trauma (American Psychiatric Association, 2000).

Sexual assault differs from most other traumas in that a human being acting intentionally is the source of the trauma (Bownes, O’Gorman & Sayers, 1991). In that respect rape can be compared to torture and physical violence. An important aspect is also that rape is sexual, an area which is private and intimate for most people.

Typical reactions in the acute aftermath of the trauma of rape are illustrated by the following example:

Two days after being raped, Lisa came for psychological treatment to Centre for Victims of Sexual Assault at Copenhagen University Hospital, accompanied by her boyfriend. During the whole session, she clung to his hand, tearful, her body tense and fear in her eyes. She appeared helpless like a little child. She was afraid of going out, afraid of being alone at home. She had hardly slept since the rape, was constantly on guard, and had difficulty breathing. Lisa felt she had no control of her reactions and emotions. Her mood shifted rapidly, she was quick-tempered and reacted furiously to small disappointments. She could not recognise herself and was afraid she was going crazy. Lisa blamed herself for the rape and for not having been able to resist the perpetrator. She did not want to talk about the experience, which seemed like a dream, had it not been for her bruises reminding her of the reality.

According to the Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV) (American Psychiatric Association, 2000), a trauma demands fulfilment of three criteria specified as traumatic 1) events, 2) experiences and 3) reactions.

1) A traumatic event is defined as “an event that involves actual or threatened death or serious injury or a threat to the physical integrity of self and others” (American Psychiatric Association, 2000, p. 467), i.e. an extraordinary extreme event.
2) A traumatic experience is defined as the person’s conception of an event as traumatic (American Psychiatric Association, 2000). Not everybody is traumatised by exposure to trauma, and the level of traumatisation can be influenced, not only by the category of traumatic event, but also by other factors connected to the event, to the individual victim, and to events and experiences subsequent to the assault (American Psychiatric Association, 2000).

3) Traumatic reactions according to DSM-IV are feelings of “intense fear, helplessness or horror” (American Psychiatric Association, 2000, p. 467), which are essentially normal responses to an extremely stressful event.

It is the experience of a trauma as traumatic that is crucial and makes a difference for development of posttraumatic responses (Spiegel, Classen & Cardëna, 1999). Trauma constitutes an abrupt disruption in ordinary daily experience, including loss of control over body, emotions and thoughts (Rossi & Cheek, 1988). When an individual is traumatised her feelings of safety, security and confidence in her surroundings, in other people, in herself and in her essential life values are challenged (Janof-Bulman, 1992). Her former life experiences are not sufficient for her to cope with the actual situation (Christianson, 1997).

The diagnoses commonly used today for describing reactions to all kinds of traumatic events are Posttraumatic Stress Disorder (PTSD), conceptualised in 1980 and Acute Stress Disorder (ASD), which appeared in 1994 (American Psychiatric Association, 2000).

**Research on trauma and sexual assault**

Before the occurrence of the diagnosis of ASD, acute responses to traumatic events were examined using a number of different instruments including assessment of PTSD. The diagnosis of ASD was developed out of the need for an acute variation of PTSD (American Psychiatric Association, 2000). Acute traumatic stress reactions and PTSD may be a sequela of all types of extreme traumatic stressors, but in rape and attempted rape, disorders are frequently found as shown in the overview of examples of surveys in Table 1 below. Since the number of prospective studies found concerning acute reactions to trauma and particularly to sexual assault was sparse and since none were found at the time of the study using validated scales of ASD, retrospective studies were also included.
Seventeen of the 18 studies presented in Table 1 covering a period of 30 years (1974-2004) included sexual assault, mainly on females, four were conducted on mixed sex groups, and nine were conducted across different traumatic events.
<table>
<thead>
<tr>
<th>Study</th>
<th>Sample description</th>
<th>Survey location</th>
<th>Mode of examination</th>
<th>Time for examination</th>
<th>Measures of trauma</th>
<th>Prevalence rates and/or most frequent reactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burgess &amp; Holmstrom (1974)</td>
<td>92 females aged 17-73 years after forcible rape / attempted rape by a stranger</td>
<td>Emergency ward, Boston, USA</td>
<td>Interview</td>
<td>Immediately after the assault. Follow-up by telephone or home visit. Repetition 4 -6 years later</td>
<td>Rape Trauma Syndrome</td>
<td>Acute disorganisation 2 - 3 weeks post trauma (physical symptoms and fear). Longer lasting reorganisation (motor activity; support seeking)</td>
</tr>
<tr>
<td>Vestergård (1974)</td>
<td>12 females aged &gt;15 after rape / attempted rape</td>
<td>Aarhus, Denmark</td>
<td>Interview (10), by letter (2)</td>
<td>Retrospective (2-20 years)</td>
<td>Qualitative evaluation</td>
<td>100% acute shock reactions and longer lasting fear reactions</td>
</tr>
<tr>
<td>Bownes, O’Gorman &amp; Sayers (1991)</td>
<td>51 females aged 16-47 (21 known assailant, 30 stranger assailant). Police reported rape</td>
<td>Queen’s University of Belfast, Northern Ireland, UK</td>
<td>Psychiatric case notes</td>
<td>Retrospective 6 months and 3 years after referral to consultant psychiatrist</td>
<td>PTSD</td>
<td>70% PTSD. Rape by strangers more violence and trauma</td>
</tr>
<tr>
<td>Rothbaum, Foa, Riggs, Murdoch &amp; Walsh (1992)</td>
<td>64 females aged 17-65 after rape / attempted rape</td>
<td>Eastern Pennsylvania Psychiatric Institute, PA, USA</td>
<td>Self-report measures and interview</td>
<td>Weekly for 12 weeks post trauma</td>
<td>PTSD, IES, RAST, STAI, BDI</td>
<td>94% PTSD within the first weeks. At 12 weeks 47 % PTSD</td>
</tr>
<tr>
<td>Dahl (1993)</td>
<td>53 females aged 15-57 after rape/ attempted rape</td>
<td>Emergency ward, Oslo, Norway</td>
<td>Interview</td>
<td>Within 2 weeks and after 3 and 12 months</td>
<td>CPRS-PTSD, IES, STAI X-1, SSL</td>
<td>89% psychophysiological stress symptoms, 77% intrusion</td>
</tr>
<tr>
<td>Echstrøm, Welner, Helweg-Larsen &amp; Theilgaard (1993)</td>
<td>18 females aged 18-54 years. Police reported rape/ attempted rape</td>
<td>Copenhagen University Hospital, Denmark</td>
<td>Questionnaire/ interview</td>
<td>Within 1 and after 6 months</td>
<td>STAI-X-1, IES, SCL-90-R</td>
<td>During the first months: phobic fear and startle response. After 6 months 50% phobic fear, depression, sense of guilt, somatic complaints</td>
</tr>
<tr>
<td>Resnick, Kilpatrick, Dansky, Saunders &amp; Best (1993)</td>
<td>4,008 females mean age 44.9 years, randomly selected</td>
<td>Medical University of SC, USA</td>
<td>Telephone interview</td>
<td>Retrospective screening</td>
<td>PTSD</td>
<td>Completed rape highest rate of lifetime PTSD (57.1%). Fear of being killed or injured lead to PTSD</td>
</tr>
<tr>
<td>Foa, Riggs &amp; Gershuny (1995)</td>
<td>158 females aged 17-65 after rape and nonsexual assault</td>
<td>Psychiatric Institute, Medical College, PA, USA</td>
<td>Interview</td>
<td>4 measurements between 10 days and 3 months after</td>
<td>PTSD, STAI, BDI, RAST</td>
<td>In rape victims 90% PTSD. High arousal and / or high avoidance → numbing</td>
</tr>
<tr>
<td>Study</td>
<td>Sample description</td>
<td>Survey location</td>
<td>Mode of examination</td>
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<tr>
<td>Koopman, Classen, Cardena &amp; Spiegel (1995)</td>
<td>15 studies of trauma survivors (no sexual assault)</td>
<td>Stanford University, CA, USA</td>
<td>Literature study on acute psychological reactions</td>
<td>Within the first month</td>
<td>ASD reactions</td>
<td>Anxiety symptoms in 14 of 15 studies</td>
</tr>
<tr>
<td>Ullman (1995)</td>
<td>2,364 mixed sex group randomly selected aged &gt;18 (11.8% sexual assault)</td>
<td>Los Angeles, USA</td>
<td>Interview</td>
<td>Retrospectively twice with 1 year interval</td>
<td>Traumatic Event Measures</td>
<td>High prevalence in sexual assault of symptoms of reexperiencing, arousal and avoidance</td>
</tr>
<tr>
<td>Dancu, Riggs, Hearst-Ikida, Shoyer &amp; Foa (1996)</td>
<td>158 assaulted females. 74 after rape. Mean age 28.8</td>
<td>Medical College of Pennsylvania, USA</td>
<td>Interviews / self-report instruments</td>
<td>Within 2 weeks and 3 times further within 3 months</td>
<td>PDS, DES, IES, SAI</td>
<td>Only rape victims elevated PTSD scores after 3 months. Dissociation highest in childhood abuse.</td>
</tr>
<tr>
<td>Falsetti &amp; Resnick (1997)</td>
<td>62 treatment-seeking persons after 15 different traumas. 78% females. Rape: 21%</td>
<td>Crime Victims Research and Treatment Centre, SC, USA</td>
<td>Standardized questionnaires/ interviews</td>
<td>Retrospective</td>
<td>BDI, SCID II, modified DIS, TAA, PRS</td>
<td>61% PTSD. 90% panic attacks during rape</td>
</tr>
<tr>
<td>Brewin, Andrews, Rose &amp; Kirk (1999)</td>
<td>157 mixed sex group aged &gt; 18 of physical or sexual assault (3.8%) or bag snatch</td>
<td>Department of Psychology, University of London, U.K.</td>
<td>Interview, re-interview by telephone</td>
<td>Within 1 month and 6-month follow-up</td>
<td>Items of PTSD Symptom Scale, SCID, IES,</td>
<td>19% ASD. 20% PTSD. Reexperiencing / Arousal symptoms predicted PTSD</td>
</tr>
<tr>
<td>Feeny, Zoellner &amp; Foa (2000)</td>
<td>104 females aged &gt;18 after sexual (56)/nonsexual (48) assault</td>
<td>University of Pennsylvania School of Medicine, USA</td>
<td>Interviews/self-report questionnaires</td>
<td>2, 4 and 12 weeks post assault</td>
<td>PSS-I, SAS, SAI, AX, DES</td>
<td>Initial anger and dissociation related to later PTSD and poor social functioning</td>
</tr>
<tr>
<td>Krakow, Gernam, Warner, Schraeder, Koss, Hollifield, Tandberg, Melendrez &amp; Johnston (2001)</td>
<td>151 females mean age 18.7 after sexual assault/unwanted sexual experiences</td>
<td>NM, USA</td>
<td>Interview / Questionnaire</td>
<td>Retrospective</td>
<td>PSQI, PSS-I</td>
<td>95% PTSD</td>
</tr>
<tr>
<td>Ehnhage-Johnsson, Skwarek, Seflin, Eriksson &amp; Boström (2003)</td>
<td>19 females aged 18-43 after rape/attempted rape</td>
<td>Open Ward, Stockholm, Sweden</td>
<td>Interview</td>
<td>After 1, 6 and 12 months</td>
<td>Qualitative evaluation</td>
<td>Serious psychological and somatic problems</td>
</tr>
<tr>
<td>Gershuny, Cloitre &amp; Otto (2003)</td>
<td>146 females aged 18-49 personally traumatized</td>
<td>Massachusetts General Hospital, USA</td>
<td>Questionnaires in group</td>
<td>Retrospective</td>
<td>TES-L, PTSD, PDEQ, FDDT, FLCDT</td>
<td>Fears about death and losing control accounted for dissociation and PTSD severity</td>
</tr>
<tr>
<td>Nixon, Resick &amp; Griffin (2004)</td>
<td>105 females aged &gt;18. Sexual (57%) and physical assault (43%)</td>
<td>Centre for Trauma Recovery, St. Louis, USA</td>
<td>Interview / Questionnaires</td>
<td>After 2 weeks</td>
<td>HVG, PRS, SCID, CAPS, Trauma interview</td>
<td>41 % panic attacks; Predicted by presence of life threat</td>
</tr>
</tbody>
</table>
As illustrated by the overview of former surveys concerning sexual assault and other traumatic experiences a great variety of methods and samples have been included, which makes a comparison of results difficult. Yet, all the studies assessing PTSD found a higher prevalence of PTSD in victims of rape or attempted rape compared to other traumas. In the acute aftermath of the experience it was found that almost all sexual assault victims suffered from posttraumatic stress (Resnick et al., 1993; Foa et al., 1995; Ulmann, 1995; Dancu et al., 1996; Falsetti & Resnick, 1997; Feeny et al., 2000).

The prospective studies of acute reactions (Burgess & Holmstrom, 1974; Dahl, 1993; Rothbaum et al.; Echstrøm et al., 1993; Foa et al., 1995; Dancu et al., 1996; Brewin et al., 1999; Feeny et al., 2000; Ehnhauge-Johnsson, 2003; Nixon et al., 2004) indicate that rape victims show disruptions in overall functioning for the first few months after their assaults, and that the most frequent acute reactions are psychophysiological stress symptoms, dissociative responses, especially emotional numbing, anxiety symptoms, and reexperiencing.

Feelings of shame, guilt, and suicidal ideation, and eating disorders in the acute aftermath seemed more prominent in victims of rape than in victims of other traumas (Burgess & Holmstrom, 1974; Dahl, 1993; Echstrøm et al., 1993; Ehnhage-Johnsson et al., 2003). Women with sexual assault histories seeking treatment also seem to have worse sleep quality than in other traumas (Krakow et al., 2001).

Several researchers have described the trauma of rape primarily as a life-threatening experience evoking fear responses in the victim (e.g. Rothbaum et al., 1991; Resnick et al., 1993; Foa et al., 1995; Koopman et al., 1995). Nixon et al., (2004) found that prior history of PTSD, perception of life threat, and the index trauma being a sexual assault all predicted post trauma panic in the acute aftermath. Falsetti & Resnick (1997) found in their retrospective study on treatment-seeking trauma persons that panic attack symptoms seems to be a common response during sexual assault.

Some of the studies mentioned in Table 1 have, however, found the content of the trauma more complicated (Bownes et al., 1993; Dahl, 1993; Echstrøm et al., 1993; Ehnhage-Johnsson et al., 2003), due to the sexual aspects and the fact that the trauma is imposed by a fellow human being. The extreme stress experienced by psychic trauma in general and sexual assault in particular may be deeply imprinted into the organism causing long-lasting disorders (Rossi & Cheek, 1988; Spiegel, 1997). Two of the studies mentioned found that trauma symptoms decreased over time (i.e. after three months post trauma or later), but psychophysiological symptoms (arousal and somatic complaints) and phobic fear reactions (avoidance), including sexual fear seemed to persist (Burgess
& Holmstrom, 1979; Dahl, 1993). Other long-term reactions found have been depression, self-blame, sense of guilt, and insecurity in human relationships (Dahl, 1993; Echstrøm et al., 1993; Ehnhage-Johnsson et al., 2003).

One of the studies (Bownes et al., 1991) found that predictors of long-term post traumatic distress were rape by a stranger, violence from perpetrator, weapons being used, and injuries being sustained.

Factors not directly connected to the sexual assault may also influence reactions. In the retrospective study of Gershuny and colleagues (2003) on personally traumatising events, an association was found between PTSD severity, peritraumatic dissociation, fears about death and losing control, number of lifetime occurrences of potentially traumatic events, and the degree of non-specific fear/helplessness/horror experienced during the event.

Ullman (1995) found in her retrospective study on different kinds of lifetime trauma in both sexes that younger adult women of sexual assault reported most post traumatic stress. Thus, factors related to the assault as well as individual differences in the victims may create great variation in the traumatised field.

**Individual differences and core features of trauma**

The consequences of being exposed to a traumatic event can be “as varied as the traumas themselves and the individuals who are victims” (López-Ibor, 2002, p. 109).

In spite of this, the core features of human response to overwhelming and uncontrollable life events seem remarkably consistent (van der Kolk, 1986). Acute reactions such as dissociation are found to be common among all traumatised individuals (Classen, Koopmann & Spiegel, 1993; Michelson & Ray, 1996). Symptoms of dissociation are the main criterion of the diagnosis of ASD. Dissociation is defined in DSM-IV (American Psychiatric Association, 2000, p. 519) as “a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment.” Dissociation may be regarded as a fragmentation in which experience is compartmentalised. Before occurrence of the ASD diagnosis the phenomenon was named differently as for example disorganisation (Burgess & Holmstrom, 1974) or shock reaction (Vestergård, 1974).

Dissociation is a neurobiological phenomenon occurring during extreme stress (van der Kolk, 1986; Krystal, Bennett, Bremner, Southwick & Charney, 1996) as a consequence of a ‘psychological shock’ or high arousal (Koopman et al., 1995; Schore, 2001). At the moment of feeling threatened,
individuals may dissociate and switch into a trance-like state “and later report out-of-body experiences and dissociative amnesia” (Schore, 2001, p. 235).

Another consequence of traumatic dissociation is emotional numbing: an inability to feel emotions of any kind, especially those associated with feelings of intimacy, love, and affection (Feeny, Zoellner, Fitzgibbons & Foa, 2000a). Amnesia as well as emotional numbing may be considered as unconscious ways of dealing with and controlling a traumatic event (Horowitz, 1997) by dissociating memories and emotions of the event from the ‘normal’ consciousness. What is overwhelming is pushed out of the consciousness as a protection against extreme emotional impact (Classen et al., 1993).

**Acute Stress Disorder**

A number of studies of ASD using validated scales of measurement following the DSM-IV criteria (American Psychiatric Association, 2000) have been carried out within a broad range of trauma, e.g. traffic accidents (Cardeña, Koopman, Classen, Waelde & Spiegel, 2000; Bryant & Harvey, 2002; Fuglsang, 2003; Briere, 2004), but no studies of sexual assault providing a formal diagnosis of ASD were found at the time of the present study.

The ASD diagnosis was selected for the present study for the following reasons:

- The diagnosis of ASD consists of characteristic symptoms occurring within one month following an extreme traumatic stressor (Criterion A) (American Psychiatric Association, 2000).

- Studies indicate that rape is one of the most devastating experiences in both men and women in relation to a traumatic aftermath (as presented in Table 1).

- ASD is considered directly comparable to PTSD (American Psychiatric Association, 2000). By the development of ASD the hope was that if risk factors of long-term consequences could be registered in the acute phase of a trauma, then the proper psychological treatment might diminish the risk.

- ASD is supposed to predicate disorders in the long run in the way that e.g. peritraumatic dissociation (dissociation at the time of the trauma), increase the risk of developing PTSD (Koopman et al., 1995; Spiegel, Koopman, Cardeña & Classen, 1996). Prospective studies
have indicated that approximately 80% of people who meet the criteria for ASD subsequently develop chronic PTSD (Bryant & Harvey, 2002; March, 2003).

Furthermore, the ICD-10 has no diagnosis for reactions after severe trauma between two days and four weeks post trauma. Acute Stress Reaction (ASR) (WHO, 1994) has several traits in common with ASD. ASR describes a passing state, which develops within one-hour post trauma and lasts for a maximum of two or three days. It is considered a normal, immediate, transient reaction to severe stress.

THE PRESENT STUDY

Rape crisis centres in Denmark have existed since 2000 and studies are few both concerning consequences\(^4\) and psychological treatment after rape. CVS is an open acute ward with an interdisciplinary staff offering medical and psychosocial examination and treatment to victims of sexual assault. CVS has an intake of 250-350 a year, which offers a solid material for research.

Aims

The study was carried out in order to access the prevalence, character and severity of ASD (American Psychiatric Association, 2000) among women enquiring at CVS. The aim was also to examine the influence of different variables on ASD responses. The selection of the six variables for the present study was made from database-registered factors connected to the rape and the victims themselves. Resistance during the assault was reported by the participants, but not database registered at the time of the study.

The variables were:

1. The woman’s age at the time of the assault.
   It was hypothesised that consequences of a sexual assault would be more devastating to a young person than to an elder person, because a young person by virtue of less experience, knowledge, a more unstable sense of self and identity, and less developed coping strategies is more vulnerable than an elder person. A young person’s possibilities of attaching meaning to the situation (Gjærum, Grøholt & Sommerschild, 2000), i.e. appraisal of the situation, and

\(^4\) As part of a master thesis in psychology a questionnaire study of 25 victims of sexual assault found an ASD prevalence of 72% (Magnúsdóttir, 2003).
employing previous experiences and actions, will also be limited compared to an elder victim and influence possibilities of integrating the trauma in the aftermath.

2. The woman’s intake of alcohol and/or drugs before the assault. If the victim reported an intake of more than five units of alcohol and/or drugs of medium or strong character (for example ecstasy, heroin, morphine) before the assault, she was considered to be under the influence of alcohol/drugs (a/d) during the assault. An intake of 0-5 units of alcohol and/or no drugs or drugs of a mild character (e.g. hashish) before the assault was considered as non-influence of alcohol/drugs (no-a/d). It was expected that the dissociative symptom of amnesia would be frequent in a/d-victims and thus constitute a risk factor in development of post traumatic stress. Prevalence and severity of post trauma distress was expected to be higher in a/d-victims than in no-a/d-victims, since it was supposed that a/d-victims more often than no-a/d-victims would suffer from feelings of loss of control, self-blame, and fear of repetition of the assault.

3. The woman’s experience of own resistance during the assault. Resistance may be verbal and/or physical. It was hypothesised that trauma symptoms would be more severe in women unable to resist during the assault, because lack of resistance may reflect that the victim had experienced the rape as life threatening.

4. The type of assault (rape/attempted rape). It was assumed that prevalence and severity of ASD would be higher in victims of consummated rape, because of the bodily invasion and the stronger feelings of mental defeat (Ehlers, Maercker & Boos, 2000) that consummated rape may evoke compared to attempted rape.

5. Physical violence or threats of violence from the perpetrator. It was assumed that violence or threats during the assault would be experienced as threats to one’s life and cause a higher prevalence and severity of ASD. Physical violence registered in CVS covers a spectre from holding to attempted strangulation.

6. The relationship between the woman and the perpetrator before the assault. It was hypothesised that rape by a stranger would elicit more fear of death during the assault compared to rape by an acquaintance. The shock effect was expected to be greater in stranger-rape and thus also the posttraumatic stress.
POPULATION AND METHODS

Participants

Since 2001 data of all admissions to CVS have been registered and kept in a quality secured database, consisting of 994 persons by the end of 2004. Of these, 446 (44.9%) have received psychological treatment at the centre. The 50 participants in the present study were selected from the 446 victims psychologically treated at CVS. The victims of the sample were between 15-44 years of age (mean age 22 years). The 50 participants were victims of rape or attempted rape consecutively admitted for psychological treatment during a period from May 2003 to April 2004. The reason for the procedure in selection of time period and participants was that the research project started in 2003 and out of consideration for the victims the assessment was made as part of the psychological treatment.

In order to examine whether the selected sample was representative of women enquiring at CVS, a comparison on demographic, personal and rape-related variables was made between all enquiries at CVS in 2001-2004 and attendance of psychological treatment as presented in Table 2.
Table 2. Comparison between all enquiries and victims attending psychological treatment at CVS 2001-2004

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>n</th>
<th>YES PSYCHOLOGICAL TREATMENT AT CVS n=446 (44.9%)</th>
<th>NO PSYCHOLOGICAL TREATMENT AT CVS n=548 (55.1%)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 15 – 29 years</td>
<td>993</td>
<td>352 (78.9%)</td>
<td>326 (59.5%)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Born in DK</td>
<td>993</td>
<td>348 (78.0%)</td>
<td>417 (76.1%)</td>
<td>0.381</td>
</tr>
<tr>
<td>Employment</td>
<td>993</td>
<td></td>
<td></td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Employed</td>
<td></td>
<td>113 (25.3%)</td>
<td>78 (14.3%)</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td></td>
<td>91 (20.4%)</td>
<td>173 (31.6%)</td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td></td>
<td>215 (48.2%)</td>
<td>220 (40.1%)</td>
<td></td>
</tr>
<tr>
<td>Prior sexual assaults</td>
<td>733</td>
<td>110 (24.7%)</td>
<td>158 (28.8%)</td>
<td>0.089</td>
</tr>
<tr>
<td>Prior psychiatric treatment</td>
<td>769</td>
<td>46 (10.3%)</td>
<td>134 (24.5%)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Abuse of alcohol / drugs</td>
<td>940</td>
<td>17 (3.8%)</td>
<td>76 (13.9%)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Chronic illness</td>
<td>946</td>
<td>101 (22.6%)</td>
<td>201 (36.7%)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Intake of alcohol &gt;5 units before the assault</td>
<td>903</td>
<td>166 (40.3%)</td>
<td>181 (36.9%)</td>
<td>0.290</td>
</tr>
<tr>
<td>Intake of drugs ≥ medium character before the assault</td>
<td>815</td>
<td>24 (6.4%)</td>
<td>55 (12.6%)</td>
<td>0.003</td>
</tr>
<tr>
<td>Type of assault</td>
<td>806</td>
<td></td>
<td></td>
<td>0.004</td>
</tr>
<tr>
<td>Rape (penetration)</td>
<td></td>
<td>283 (76.1%)</td>
<td>365 (84.1%)</td>
<td></td>
</tr>
<tr>
<td>Attempted rape</td>
<td></td>
<td>89 (23.9%)</td>
<td>69 (15.9%)</td>
<td></td>
</tr>
<tr>
<td>Physical violence 1</td>
<td>994</td>
<td>293 (65.7%)</td>
<td>344 (62.8%)</td>
<td>0.340</td>
</tr>
<tr>
<td>Threats of violence</td>
<td>994</td>
<td>138 (30.9%)</td>
<td>149 (27.2%)</td>
<td>0.190</td>
</tr>
<tr>
<td>Relationship to perpetrator</td>
<td>954</td>
<td></td>
<td></td>
<td>0.012</td>
</tr>
<tr>
<td>Partner/ex-partner</td>
<td></td>
<td>46 (10.5%)</td>
<td>78 (15.2%)</td>
<td></td>
</tr>
<tr>
<td>Friend or other acquaintance (&gt;24 hrs) 2</td>
<td></td>
<td>132 (30.0%)</td>
<td>181 (35.2%)</td>
<td></td>
</tr>
<tr>
<td>Occasional acquaintance (&lt;24 hrs)</td>
<td></td>
<td>112 (25.5%)</td>
<td>115 (22.4%)</td>
<td></td>
</tr>
<tr>
<td>Stranger</td>
<td></td>
<td>137 (31.1%)</td>
<td>120 (23.3%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>13 (3.0%)</td>
<td>20 (3.9%)</td>
<td></td>
</tr>
<tr>
<td>Scene of the crime</td>
<td>965</td>
<td></td>
<td></td>
<td>0.060</td>
</tr>
<tr>
<td>Own or perpetrator’s home</td>
<td></td>
<td>194 (44.1%)</td>
<td>263 (50.1%)</td>
<td></td>
</tr>
</tbody>
</table>

1. Drugs ≥ medium character = e.g. ecstasy, heroin, morphine. Drugs of mild character are e.g. hashish.
2. Physical violence covered a spectrum from holding to attempted strangulation.
3. There is differentiation between perpetrators known more than 24 hours and perpetrators known less than 24 hours.

From the comparison it appears that there are many similarities between the group, which attended psychological treatment at CVS 2001-2004 and the group, which did not. The clearest differences
found between the groups were on age, employment, prior psychiatric treatment, abuse of alcohol/drugs and chronic illness.

Victims attending psychological treatment at CVS were found to be younger and more often employed or students than the group not attending psychological treatment, while the latter more often reported prior psychiatric treatment, abuse of alcohol/drugs and chronic illness. Victims attending psychological treatment thus seemed more resourceful than the group, who did not accept psychological therapy. The difference corresponds to the findings of an earlier study made by the researcher (Rust, 2001) on differences between victims accepting the offer of psychological contact at CVS and those who did not (N=158): The victims who declined treatment or ended it after one or two sessions seemed to have had a higher level of psychosocial strain at the time of or prior to the assault, e.g. incest, previous rapes, violent partnerships, alcoholism or substance abuse.

A comparison was also made in relation to the variables examined in the present study between the sample group and the rest of the group who had received psychological treatment at the centre (Table 3). Experienced resistance was not a database-registered variable at the time of the study and thus not comparable.
Table 3. Comparison between the sample and the rest of attendants of psychological treatment at CVS 2001-2004

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>n</th>
<th>ATTENDENTS MINUS SAMPLE</th>
<th>THE SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=396</td>
<td>n=50</td>
<td>P</td>
</tr>
<tr>
<td>Age 15-29 years</td>
<td>396</td>
<td>310 (78.3%)</td>
<td>50</td>
</tr>
<tr>
<td>Alcohol/drugs intake(^1)</td>
<td>353</td>
<td>152 (43.1%)</td>
<td>48</td>
</tr>
<tr>
<td>Type of assault</td>
<td>372</td>
<td>248 (65.9%)</td>
<td>50</td>
</tr>
<tr>
<td>Rape (penetration)</td>
<td>396</td>
<td>261 (66.9%)</td>
<td>50</td>
</tr>
<tr>
<td>Attempted rape</td>
<td>396</td>
<td>127 (32.1%)</td>
<td>50</td>
</tr>
<tr>
<td>Physical violence(^2)</td>
<td>396</td>
<td>261 (66.9%)</td>
<td>50</td>
</tr>
<tr>
<td>Threats of violence</td>
<td>396</td>
<td>127 (32.1%)</td>
<td>50</td>
</tr>
<tr>
<td>Relationship to perpetrator</td>
<td>391</td>
<td>49</td>
<td>0.770</td>
</tr>
<tr>
<td>Partner/ex-partner</td>
<td>43</td>
<td>11 (11.0%)</td>
<td>3 (6.1%)</td>
</tr>
<tr>
<td>Friend or other acquaintance (&gt;24 hrs)(^3)</td>
<td>118</td>
<td>30.2%</td>
<td>14 (28.6%)</td>
</tr>
<tr>
<td>Occasional acquaintance (&lt;24 hrs)</td>
<td>97</td>
<td>24.8%</td>
<td>15 (30.6%)</td>
</tr>
<tr>
<td>Stranger</td>
<td>121</td>
<td>30.9%</td>
<td>16 (32.7%)</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>3.1%</td>
<td>1 (2.0%)</td>
</tr>
</tbody>
</table>

1. Alcohol > 5 units and/ or drugs ≥ medium character
2. Physical violence covered a spectre from holding to attempted strangulation.
3. There is differentiated between perpetrators known more than 24 hours and perpetrators known less than 24 hours.

There were no significant differences found between the sample and the rest of attendants of psychological treatment. The number of a/d-victims was a little higher in the sample. In relation to the variables examined the 50 participants of the present study are thus considered acceptable as representatives of the whole group that attended psychological treatment at CVS in 2001-2004.

The ASDS scale

At the time of the study the Acute Stress Disorder Interview (ASDI) (Bryant, Harvey, Dang & Sackville, 1998; Bryant & Harvey, 2002) was the only structured clinical interview that had been validated against DSM-IV criteria for ASD (Appendix A, p.186). Another instrument with good reliability and validity according to acute trauma reactions is the Stanford Acute Stress Reaction Questionnaire (SASRQ) (Cardeña et al, 2000), but it does not provide a formal diagnosis of ASD.
(Cardeña et al., 2000; Bryant & Harvey, 2002). The SASRQ may also be best applicable in studies of large populations (Cardeña et al., 2000).

The interview form of examination was chosen instead of a questionnaire form, in order to attain more detailed reports. The Acute Stress Disorder Scale (ASDS) (Bryant & Harvey, 2002) was employed because it contains a subdivision of the degree of the individual symptom, which the ASDI does not. The subdivision makes it possible to examine responses in greater detail. The ASDS is a self-report questionnaire measure of ASD symptoms, which is significantly correlated with symptom clusters on the ASDI (Bryant & Harvey, 2002).

The ASDS consists of nineteen questions and is divided into four clusters of symptoms concerning cognitive, emotional and psychophysical reactions. The symptom clusters are: dissociation (divided into emotional numbing, reduced awareness, depersonalisation, derealisation, amnesia), invasion (intrusive thoughts and images, dreams, sense of reliving the trauma, and distress on exposure to reminders of the trauma), avoidance (not thinking about the trauma, not talking about the trauma, avoiding places or people that are reminders of the trauma, and active avoidance of distress), and symptoms of hyperarousal and fear (insomnia, irritability, concentration deficits, hypervigilance, elevated startle response, and autonomic arousal) (Bryant et al., 1998; American Psychiatric Association, 2000). Scores are from 1-5: 1 (not at all), 2 (mildly), 3 (medium), 4 (quite a bit), 5 (very much); total scores are from 19-95. Criteria of ASD of the ASDS scale are a dissociation score ≥ 9 (and a score more than 1 in at least three out of the five symptom items of dissociation) and a total score ≥ 28 for responses on the other three cluster categories (invasion, avoidance, and hyperarousal) (Bryant & Harvey, 2002). There is no Danish standardisation of the ASDS, so to diminish this bias a ‘back translation’ (American Psychological Association, 2002) method was employed, in which the questions of the scales were translated into Danish by the researcher and then back into English by a person proficient in English, and after that compared and corrected where it was necessary according to the English wording to ensure that the translation was equivalent enough to make the scores comparable with scores of other studies. The scale has been used in a Danish study of traffic accident victims (Fuglsang, 2003), but the wording of the present translation differs a little from that translation to fit the English version better. The version employed in the present study has been used with more than one hundred rape victims at CVS.
Procedure

The assessment of ASD was carried out on average 7 days after the sexual assault (2 - 27 days) and took place in the clinic, where the women had been treated. The 50 women (aged 15-44 years) participating in the study were initially divided into age groups with a five-year interval, but since only 6 persons were above 30 years of age, they were made into one group. Since reactions in the youngest participants differed from other age groups, it was decided to divide the group of 15-19 years old into two groups (15-17 years old and 18-19 years old).

More than half of the women had been under the influence by alcohol and/or drugs during the assault (a/d) and thus there may be doubts as to whether they meet the diagnostic criterion H of ASD (“The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical illness etc.”) (American Psychiatric Association, 2000, p. 472). A diagnosis of ASD cannot be made if the disturbance is better accounted for by a medical condition or substance use. Influence by alcohol or drugs during the trauma may have created alterations in awareness that can resemble dissociative symptoms. It seemed justified to ignore obtaining fully proof of fulfilment of criterion H for the following reasons: 1. Many unknown individual variables besides the trauma may influence development of ASD, e.g. premorbid disorders as depression, anxiety, and psychosomatics. 2. Victims influenced by alcohol or drugs reported distinct stress reactions not only on dissociation, but also on all other symptom clusters of ASDS confirming the reliability of the diagnosis. 3. It was found that dissociative symptoms were most conspicuous in no-a/d-victims, which was interpreted as a justification of accounting for responses of the women influenced by a/d by the diagnosis of ASD.

Because of the high percentage of a/d-victims, it was decided to make the analysis on three groups: the a/d group with ASD, the no-a/d ASD group, and the no-ASD group. Of the a/d group 53.8% thought that the perpetrator had drugged them.

Statistical methods

Information for the present study was drawn from the general database of CVS based on registration forms for each attendant. The database contains information on the assault and medical treatment and other information relevant to the assault, such as prior medical history and sociodemographic data. Data from this general database was recoded and transferred to a separate database supplemented with data from the present study.
The SPSS package 11.0 was used for the data analysis. The Pearson Chi-Square test was used to test differences in proportions between groups (Nielsen & Kreiner, 1999; Burns & Bush, 2000). Since the cell sizes were small, Fisher’s exact test was also used (Rosenthal, Rosnow & Rubin, 2000). As the continuous variables age and mean scores of different items and clustered symptoms were not normally distributed, Mann-Whitney test was used to test whether age and mean scores were different between two groups (Burns & Bush, 2000). P-values of ≤ 0.050 were referred to as statistically significant. All scores within each of the four cluster categories of ASDS were added up and a mean score was estimated for each subcategory. The scores of ASDS were examined in relation to six variables (age, intake of alcohol and/or drugs before the assault, resistance, rape/attempted rape, violence/threats of violence, and relationship between victim and perpetrator prior to the assault).

RESULTS

Prevalence of ASD

All criteria of the ASD diagnosis (American Psychiatric Association, 2000) were met by 36.0% and ignoring the uncertainty about fulfilment of criterion H, by 88.0%. The results and analysis are thus made up on a group of 44 (88.0%) assessed as suffering from ASD and a group of 6 (12.0%) assessed as not meeting the criteria for ASD, mainly because they did not fulfil the criterion of dissociation. The highest score was on symptoms of hyperarousal, also for the no-ASD group.

ASD in relation to variables of sexual assault

In order to examine the influence of other factors than the assault on development of ASD a comparison was made between victims with ASD and victims without ASD in relation to the six variables assumed to influence assessment outcome. The result is shown in Table 4. Experienced resistance was not a database-registered variable at the time of the study, but 64.0% of all participants reported that they had not been able to resist the perpetrator actively. While 5 out of 6 (83.3%) of the no-ASD group reported having resisted the perpetrator actively physically and/or verbally, only 34.6% of the a/d group with ASD (n=26), and 22.2% of the no-a/d ASD group reported this (n=18).
Table 4. Potential predictors of ASD

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>n</th>
<th>VICTIMS WITH ASD n=44 (88 %)</th>
<th>n</th>
<th>VICTIMS WITHOUT ASD n=6 (12 %)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median (25-75 percentile) age (years)</td>
<td>44</td>
<td>21 (18-27)</td>
<td>6</td>
<td>27 (20-40)</td>
<td>0.072</td>
</tr>
<tr>
<td>Alcohol/drugs intake</td>
<td>43</td>
<td>26 (59.1%)</td>
<td>5</td>
<td>1 (20.0%)</td>
<td>0.084</td>
</tr>
<tr>
<td>Type of assault</td>
<td>39</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>0.320</td>
</tr>
<tr>
<td>Rape (pentrantion)</td>
<td>31</td>
<td>79.5%</td>
<td>4</td>
<td>100%</td>
<td>0.320</td>
</tr>
<tr>
<td>Attempted rape</td>
<td>8</td>
<td>20.5%</td>
<td>0</td>
<td>0.0%</td>
<td>0.320</td>
</tr>
<tr>
<td>Physical violence</td>
<td>44</td>
<td>26 (59.1%)</td>
<td>6</td>
<td>6 (100%)</td>
<td>0.050</td>
</tr>
<tr>
<td>Threats of violence</td>
<td>44</td>
<td>36 (81.8%)</td>
<td>6</td>
<td>3 (50.0%)</td>
<td>0.078</td>
</tr>
<tr>
<td>Relationship to perpetrator</td>
<td>43</td>
<td>2 (4.7%)</td>
<td>6</td>
<td>1 (16.7%)</td>
<td>0.330</td>
</tr>
<tr>
<td>Partner/ex-partner</td>
<td>11</td>
<td>25.6%</td>
<td>3</td>
<td>50.0%</td>
<td>0.330</td>
</tr>
<tr>
<td>Occasional acquaintance (&lt; 24 hours)</td>
<td>15</td>
<td>34.9%</td>
<td>0</td>
<td>0.0%</td>
<td>0.330</td>
</tr>
<tr>
<td>Stranger</td>
<td>14</td>
<td>32.6%</td>
<td>2</td>
<td>33.3%</td>
<td>0.330</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2.0%</td>
<td>0</td>
<td>0.0%</td>
<td>0.330</td>
</tr>
</tbody>
</table>

The victim was dissociated with a score ≥ 9 (at least 3 out of 5 reactions of dissociation) and a score ≥ 28 for reactions on the other three cluster categories.
1. Mann-Whitney test
2. Alcohol > 5 units and/ or drugs ≥ medium character
3. Physical violence covered a spectre from holding to attempted strangulation.
4. There is differentiated between perpetrators known more than 24 hours and perpetrators known less than 24 hours.

Victims with ASD were generally younger than victims without ASD (mean age 21.0 years vs. 27.0 years).

Of the whole sample 54.0% had been under the influence by alcohol and or/drugs during the assault. Only one person of this group was not suffering from ASD.

An association was found in relation to physical violence, where all of the victims without ASD reported having been exposed to physical violence, compared to 59.1% of the ASD group. No association was found between development of ASD and the type of assault; nor between ASD and the relationship between victim and perpetrator before the assault.

ASD and age
Victims aged 15-24 years had a higher prevalence of ASD than victims above 25 years of age.

The women aged 15-17 years had all developed ASD post trauma. An association was found between ASDS scores of alertness to danger and age: The youngest, the 15-17 years old and the eldest, the 30-44 years old reported less alertness to danger than the other age groups (in scores 4 and 5: 53.6% vs. 78.0% in the 18-29 years old) (p=0.041).
ASD and intake of alcohol and/or drugs before the assault
There was no association between development of ASD and intake of alcohol/drugs before the
assault, but a comparison between the a/d group with ASD and the no-a/d group with ASD showed
that the no-a/d group scored highest, except on the symptom cluster of avoidance (Table 5).

Table 5. Median (25 - 75 percentile) scores of the ASDS symptom clusters
in victims with ASD according to alcohol/drugs intake

| SYMPTOM CLUSTER                  | INTAKE OF ALCOHOL / DRUGS | NO INTAKE OF ALCOHOL / DRUGS | P  
|----------------------------------|---------------------------|-------------------------------|------
| Mean of dissociation (5 items)   | 3.6 (3.0–4.3)             | 4.0 (3.4–4.3)                 | 0.318|
| Mean of invasion (4 items)       | 3.0 (2.5–3.3)             | 3.8 (2.8–4.3)                 | 0.037|
| Mean of avoidance (4 items)      | 4.0 (2.8–4.5)             | 3.5 (2.9–4.5)                 | 0.910|
| Mean of hyperarousal (6 items)   | 3.8 (3.2–4.4)             | 4.2 (3.6–4.8)                 | 0.083|

1. Mann Whitney test

Also in the symptom of dissociative amnesia did the no-a/d group with ASD more frequently score
high (scores 4 and 5) than the a/d ASD group (55.0% vs. 50.0%). The largest difference found
between the two groups was on the symptom cluster of invasion (p=0.037). Associations were
found between individual ASDS items and influence of alcohol/drugs during the assault: In the item
of avoidance of feeling upset or distressed of the symptom cluster of avoidance did the a/d group
more often score high (scores 4 and 5) than the no-a/d group (63.0% vs. 44.6%) (p=0.031). On the
other hand, in the item problems with sleeping of the symptom cluster of hyperarousal, did the no-
a/d group more often score high (scores 4 and 5) than the a/d group (81.0% vs. 37.0%) (p=0.029).
A comparison between ASD, age and intake of alcohol/drugs before the assault showed that
young victims (aged <25) with ASD more often had been under the influence of alcohol/drugs than
the elder: Among the 15-17 years old 57.1% had been under the influence of alcohol/drugs during
the assault. They made up 36.4% of the whole a/d group with ASD. The group least influenced by
alcohol/drugs during the assault was the 30-44 years old (33.3%).

ASD in relation to physical violence from perpetrator
In relation to victims with ASD it was found that only 10 of the 26 victims, who had been under the
influence of alcohol/drugs during the assault reported having been exhibited to violence from the
perpetrator compared to 16 of the 18 victims with ASD, who had not been influenced by a/d during
the assault. Furthermore, in all but one case of the a/d group did the violence exposed consist in
holding only.
**Summary**
Most of the victims examined fulfilled the diagnosis of ASD, and the prevalence was highest in victims below 25 years of age. In relation to severity, a/d victims scored lower on symptom clusters than no-a/d victims, except on the symptom cluster of avoidance.

**DISCUSSION**

**ASD in victims of sexual assault**

Before conducting the present study it was assumed that post traumatic stress was associated with each of the six variables included in the study. The assumption was not confirmed, since only physical violence from the perpetrator was associated with ASD severity, but reverse of what was expected: Participants not fulfilling a diagnosis of ASD reported the highest occurrence of physical violence. Age and intake of alcohol and/or drugs in the victim before the assault also seemed to influence ASD responses as described below (p. 93f). However, the prevalence and severity of ASD was found to be high, as expected. The result corresponds to findings from studies mentioned above in demonstrating the devastating impact of sexual assault. Even for the victims registered as not suffering from ASD, reactions were conspicuous.

**Life threat and hyperarousal**

Since rape is an invasion of the body there is a direct threat to physical integrity (Herman, 1995; Krakow et al., 2001). The most frequent symptoms found in the present study were symptoms of hyperarousal (insomnia, irritability, concentration deficits, hypervigilance, elevated startle response, and autonomic arousal), indicating that a rape experience result in a high level of emotional tension. The result accords with findings from other studies on sexual assault. Burgess & Holmstrom (1974) found that physical symptoms and feelings of fear were especially noticeable in the acute phase, and the most frequent acute symptom found in Dahl’s study (1993) was hypervigilance. Echstrøm and colleagues (1993) and Falsetti & Resnick (1997) found in their studies that the most frequent acute symptoms reported were fear of dying, phobic fear and startle response. The study thus confirms the damaging impact of a rape experience on the normal regulation of the physical condition.

*Arousal* is primarily a physiological response (Christianson, 1997) to intense fear and anxiety. One may say, “The body is primed to respond with hyperarousal” (Janoff-Bulman, 1992, p. 69). *Arousal* mainly operates at a subconscious level, i.e. outside personal control as part of the individual’s instinctive ‘survival mode’ (Foa, Zinberg & Rothbaum, 1992). Faced by danger the organism’s
biologically prepared reactions of *fight, flight* (wanting to ward off the threat by fighting it or fleeing from it) or *‘freezing’* (tonic immobility) (Christianson, 1997; van der Kolk, 1996; Rotschild, 2000; Barlow, 2004) are elicited. When none of these reactions are helpful in avoiding the danger, the organism is overwhelmed, and symptoms of hyperarousal in the aftermath may be a consequence as seen in the present study. Another consequence than *hyperarousal* if physical escape is not possible is the occurrence of the neurobiological phenomenon of *dissociation*, as a means of psychological escape (van der Kolk, 1986; Krystal et al., 1996).

**Dissociation – a tool of survival**

In the present study the symptom cluster of *dissociation* showed the second highest score in victims diagnosed with ASD. Victims with ASD scored high in both hyperarousal and dissociation. Dissociation has been found to be common among all traumatised individuals (Classen et al, 1993; Foa et al., 1995; Michelson & Ray, 1996), but sexual assault victims seem to dissociate more than victims of other traumas (Dancu et al., 1996). The association found between dissociation and hyperarousal in ASD victims of the present study correlates with findings from other studies, where a strong association has been demonstrated between *severity* of posttraumatic stress, fears about death and losing control, and peritraumatic dissociation (Atchison & McFarlane, 1994; Gershuny et al., 2003; Nixon et al., 2004). Dissociation may be conceptualised as “a submission and resignation to the inevitability of overwhelming, even psychically deadening danger” (Schore, 2001, p. 232).

The fact that victims not diagnosed with ASD in the present study had a high hyperarousal score, but a low score of dissociation might reflect that this group experienced less fear of death during the assault than the ASD group. This is not examined, however.

**Coping with avoidance**

Victims with ASD in the present study appeared to have marked reactions of *avoidance* of stimuli that may remind of the trauma. Avoidance behaviour is frequently found in rape victims in the short as well as the long-term (Echstrøm et al., 1993; Foa et al., 1995; Ullman, 1995).

Avoidance may be considered as phobic fear reactions, probably like symptoms of hyperarousal and dissociation related to the experience of the assault as a threat to death. This emotionally focused coping (Lazarus, 1993) is, however, considered unhelpful for the majority of trauma victims (Garber & Seligman, 1980; Brewin & Holmes, 2003; Antonovsky, 2000), since attempts to suppress unwanted thoughts usually implies that the thoughts may return more strongly afterwards (Bolton & Hill, 1996).
Invasion and loss of control
Three thirds of the ASD-victims of the present study suffered from intrusive experiences post-assault specified in ASD as symptoms of intrusive thoughts and images, dreams, sense of reliving the trauma, and distress on exposure to reminders of the trauma (Bryant et al., 1998; American Psychiatric Association, 2000). An association was found between intake of alcohol/drugs before the assault and invasion, with the no-a/d group scoring considerably higher than the a/d-group. This difference will be discussed below.

Reexperiencing itself triggers general physiological arousal, which strengthens the memory trace and continued reexperiencing (van der Kolk, 1996). In Dahl’s study of 1993, intrusions were the second most frequent symptoms. Falsetti & Resnick (1997) found in their study of treatment-seeking persons that 90% of rape victims reported four or more panic reactions at the time of the rape, and this was seen as indicative of panic attack symptoms as a common response during sexual assault. The findings support a model of panic as a conditioned response to trauma, which is triggered by trauma related cues (Falsetti, Resnick, Dansky, Lydiard & Kilpatrick, 1995; Falsetti & Resnick, 1997; Gershuny & Thayer, 1999).

The trauma may appear so potent in the aftermath that just one aspect resembling the trauma situation may trigger all of it; be it emotional, physical, social, or cognitively, and the person is flashed back into the trauma again (Rossi & Cheek, 1988; Loewenstein, 1993; Rossi, 1993; Falsetti et al., 1995; van der Kolk & McFarlane, 1996).

The reason for these intrusions may be due to the phenomenon of imprinting. Imprints are impressions and experiences encoded in overwhelming emotional situations (van der Kolk, 1986; Spiegel, 1997) as nonverbal memory traces, and they occur because they are important for our survival.

Variables influencing ASD
Among the variables examined in the present study physical violence was most often reported by victims not suffering from ASD and victims with ASD that had not been under the influence by alcohol and/or drugs during the assault. Age seemed to influence development of ASD with a higher prevalence and severity of ASD in young victims compared to elder.
The vulnerability of being young

The highest scores of ASD in the present study were found in the youngest group, the 15-17 years old. The hypothesis that consequences of a sexual assault would be more devastating to a young person than to an elder person was thus confirmed.

The result corresponds to the findings of Ullman in her survey on lifetime traumatic events (1995): younger adults reported more posttraumatic stress symptoms than elder women.

It is likely that the trauma has a more devastating impact if a person is unable to integrate the traumatic event into conscious self-awareness. An explanation of the high scores of ASD in the young women of the present study could be that the younger the person is, when the trauma occurs, the less is the capacity for integration of information, and the greater the psychological damage (Classen et al., 1993). Dissociative capacities are found to be higher in young people than in elder (Atchison & McFarlane, 1994). This capacity may imply that traumatic events in young people and children are “particularly poorly integrated, leading to a vulnerability to dissociative disorders in later life” (Schore, 2002, p. 21).

Burgess & Holmstrom (1974) also found an age difference in their studies, but the only difference specified was that women over age 30 more often exposed rape-related symptoms compounded with reactivation of symptoms of previous problems. This association was not examined in the present study, but it was found that victims below 18 years of age and above 30 reported less alertness to danger than the 18-29 years old. An explanation of this finding concerning the youngest victims could be that they had not fully developed an understanding of what the signals of danger might be, and therefore would be less able to protect themselves than those who were older.

Concerning women above 30, an explanation of less alertness to danger might be that having more life experience than younger women could be helpful in preventing the rape experience from being generalised.

The influence of alcohol/drugs during the assault

It was expected that prevalence and severity of post trauma distress would be higher in a/d-victims than in no-a/d-victims of the present study, because it was assumed that a/d-victims more often would suffer from feelings of loss of control, self-blame, and fear of repetition of the assault.

Contrary to expectations the no-a/d group displayed more severe symptoms of ASD compared to the a/d group. Especially for symptoms of hyperarousal and invasion did the no-a/d group score distinctly higher than the a/d ASD group.
In studies of reactions to rape it is necessary to take into account the fact that the victims in many cases are influenced by alcohol or drugs during the assault, either voluntarily or by being drugged (Clum, Nishith & Calhoun, 2002; Center for Voldeægsofre, 2004) (between 40-60% admitted to CVS). Alcohol and drugs were involved within all age groups of the present sample, but it was striking that toxics were so frequently involved in sexual assault of the youngest ones, the 15-17 years old. That so many of the young victims had been under influence of alcohol/drugs during the assault may be understood in the light that young Danes in general consume a huge amount of alcohol. According to The National Health Service of Denmark (Ringgaard, Nissen & Nielsen, 2005) Danes between 16-20 years old possess the European record of drinking: 93% of boys and 90% of girls drink alcohol.

In a Swedish study of 47 women of sexual assault, the majority of them had been under the influence of alcohol (Ehnstage-Johnsson et al., 2003). Of these women, 36% reported that they thought they had been drugged. Studies in Great Britain (White, 2004) indicate that reported involvement of alcohol and drugs have increased markedly in sexual assault during the last ten years (from 30% to 73%), especially among teenagers.

Close to half of the entire sample of the present study reported total or partial amnesia, and it was assumed that amnesia would be more frequent in victims influenced by alcohol and/or drugs during the assault. Even though we are concerned with traumatic events it is surprising, however, that the no-a/d ASD group had a higher frequency of amnesia than the a/d ASD group. It seems to confirm the experience of a sexual assault as a life-threatening situation, causing dissociation, amnesia being the most severe symptom of this phenomenon.

In the present study the victims with amnesia developed ASD, despite reporting being unconscious during the traumatic event. Even if they could not recall the assault, the women had developed psychophysiologic reactivity to stimuli associated with the traumatic experience, as indicated by the high prevalence of hyperarousal reactions. The victims may have acquired Pavlovian conditioned fear responses established subcortically in the absence of awareness (Falsetti & Resnick, 1997; Brewin et al., 1999). They “know without awareness” (Koopmann et al., 1995), which is reflected in their reexperiencing symptoms (McNally, 2003).

What is encoded during an extremely stressful event is what is important for survival, and what is remembered is also primarily aspects of importance for survival (Foa et al., 1992), which can make it difficult to recall the event as a connected whole. Furthermore, recollections of traumatic experiences will often happen unintentionally as uncontrollable intrusions and psychophysiologic
reactivity (Brewin & Holmes, 2003), provoked by aspects reminding one of the original trauma, where you enter a similar state of mind as during the trauma (Rossi, 1993).

Symptoms of invasion and problems with sleeping were distinctly more frequent in no-a/d-victims of the present study, which may indicate that influence of alcohol/drugs to some degree functions as protection against traumatisation, at least in the acute phase. Other studies have found that alcohol consumption before sexual assault may reduce stress responses (Sayette, 1999; Clum et al., 2002). On the other hand, victims may have strong feelings of self-blame and shame, if they have been under influence of alcohol/drugs during the assault (Rust, 2005), but this relation was not specified in the present study.

The impact of experienced resistance during the assault
It was hypothesised that trauma symptoms would be more severe in women unable to resist during the assault, because lack of resistance may be connected to the degree of life-threat experienced during the assault. No association was found, but whether the person had been under the influence of alcohol/drugs or not during the assault, the experience of trauma seemed to have had an inhibiting influence on the individual’s capacity to react actively. A possible explanation of non-resistance during trauma may be that action is inhibited during intense emotion (Schore, 2001), since all affect has a psychological as well as a physiological component (Chefetz, 2000; López-Ibor, 2002). Neurologically, the explanation is that intense emotion appears to activate the Amygdala (the major fear centre in the brain) and reduce hippocampal processing (essential in the formation of memories) (Schore, 2001).

More of the a/d group compared to the no-a/d ASD group reported active resistance during the assault. If the a/d group had resisted more actively than the no-a/d group it would be expected that the physical violence exposed to this group would be more severe; but on the contrary, in all but one case concerning the a/d group, the violence consisted in holding only. It cannot be excluded, however, that the victims’ experiences and memory may be distorted by the influence of alcohol/drugs. Although it is in agreement with results of other studies that victims who are under the influence of alcohol/drugs during the assault are less prone to have physical injuries than others (White, 2004), a closer study of a greater sample is needed for explanation of these relations.

The type of assault (rape/attempted rape)
It was assumed that prevalence and severity of ASD would be higher in victims of consummated rape compared to attempted rape, because of the bodily invasion and the stronger feelings of mental defeat (Ehlers et al., 2000) that consummated rape may evoke. This was not confirmed. A reason
for this may be that a person who succeeds in preventing the rape may be invaded in the aftermath not only by memories and thoughts of the actual event but also by imaginations of how it would have been if she had been raped. Victims succeeding in escaping from being raped also have a tendency to blame themselves in the aftermath for their symptoms of traumatic stress (Rust, 2005), since the escape is understood as if ‘nothing has happened’. The prevalence of attempted rape was highest in the no-a/d group, perhaps indicating that intake of a/d constitutes a risk factor in exposure to rape, because a person influenced by alcohol or drugs is less alert.

**Physical violence or threats of violence from the perpetrator**

It was assumed that violence or threats during an assault will be experienced as threats to one’s life and therefore result in a higher prevalence and severity of ASD. Contrary to expectations violence from the perpetrator in the present study was associated with no-ASD. One explanation for this finding might be that the rape itself in victims with ASD was experienced as violence and a threat to life, which may have overshadowed other threatening aspects of the event.

The result of the findings of the present study needs to be re-examined, however, and verified by further studies with a larger sample.

Other studies have found that fear of being killed or injured during trauma lead to post traumatic stress (Bownes et al., 1991; Resnick et al., 1993; Gershuny et al., 2003; Nixon et al., 2004). The results are not directly comparable to the results of the present study, because of differences in samples and methods. Bownes et al. (1991), for example, who examined rape victims six months and three years post-rape, found that physical force being used, weapons being displayed, and injuries being sustained by the victim, was all higher in the group of women, who had PTSD. The study of Bownes and colleagues differs from the present study by only encompassing rapes reported to the police and most of the rapes were carried out by strangers (72%), while in the present study only 58% reported the assault to the police and only 32% were raped by a stranger. The validity of the study of Bownes and colleagues can also be questioned, since it was a retrospective study based on psychiatric case notes. Even if the results of the present study on associations between variables and ASD do not correspond to associations found in other studies, it is possible that characteristics related to the sexual assault may influence trauma reactions in the long-term.

**The relationship between the victim and the perpetrator before the assault**

It was hypothesised that rape by a stranger would elicit more fear of death during the assault compared to rape by an acquaintance and thus elicit more severe post traumatic stress. Other studies
e.g. the study by Bownes et al. (1991) has found a higher prevalence of PTSD in victims raped by strangers, but this assumption was not confirmed by the present study.

Summary
Not all the assumptions put forward in the present study were confirmed. A high prevalence and severity of ASD was found as expected. Concerning associations between the six variables examined and development of acute post traumatic stress, young age seemed to be a risk factor in eliciting severe distress post trauma. Intake of alcohol and/or drugs in the victim before the assault, seemed, contrary to expectations, to moderate post traumatic stress responses. The study did not confirm assumptions that severity of ASD would be increased if victims had not resisted the perpetrator actively during the assault, if victims had been exposed to physical violence during the assault, nor if the rape had been committed by a stranger. The results of the study can be called into question, however, as described in the following section and further studies will be necessary in order to verify the results.

Shortcomings
This is the first study in Denmark assessing ASD in victims of rape and attempted rape according to a scale validated against DSM-IV criteria. No international studies using the same scale in sexual assault were found at the time of the study, which makes comparisons difficult. The reliability and validity of the research can be questioned at several points: First of all the instrument employed has not been standardised in a Danish sample, although this bias was accounted for to some extent by employing a ‘back translation’ method (American Psychological Association, 2002) and by testing the scale on a larger number of victims than the sample included in the study. The ASDS scale was, however, found to be the best possible diagnostic instrument in assessing acute stress reactions at the time the study was made. Other biases are connected to the researcher and the participants of the study. Researcher bias: The researcher’s mixture of roles (researcher, psychologist, therapist for the subjects in the research, and being a woman with women victims) has implied an alternation between what can be defined as a participatory and a non-participatory research role (Johnson & Turner, 2003), and this has affected the study and its results. The researcher’s being part of a special cultural context, i.e. the CVS, has implied a selective perception in deciding on the focus of the research, and in describing the reactions in the women and analysing the material. The relationship between the subjects and the researcher as a therapist
and as a woman has also influenced results. An advantage of the researcher’s mixture of roles has been her therapeutic contact with victims of rape which has given her knowledge and experience of rape victims’ reactions and needs.

**Sampling bias:** Validity shortcomings in collection and analysis of data were related to the composition of participants in different ways: Subjects were psychologically treated victims enquiring at CVS and no control group was included. This was not an ideal composition, but the best possible with the time and resources available. The selection of participants seemed justified, since also information on non-treated victims at CVS was included from the data based registration of all enquiries. The subjects included in the study differed to some extent from the whole sample of enquiries to CVS, since the acceptance of psychological treatment seemed to depend mainly on other variables than those directly connected to the sexual assault. Individuals who had other difficult conditions of life besides the sexual assault had not so frequently as others made use of the offer of psychological treatment. One reason for this may be that early interactive traumatic experiences “determine whether, in later times of crisis, the individual can allow himself to go to others for interpersonal support….” (Schore, 2001, p. 245), included professional support. The women accepting the offer of psychological treatment at CVS generally seemed more resourceful than those who did not accept the offer. To face the reality of the impact of a sexual assault, and go through the pain of integrating the experience, certainly demands personal resources. Like one woman said at a treatment session with the researcher: “I am not here because I want to, but because it is necessary.” The fact that the study group included a higher percentage of 15-29 years old women compared to all enquiries at CVS may have influenced the prevalence of ASD, since young victims were found to score higher in the ASDS than older victims. On the other hand, the fact that the majority of women attending psychological treatment at CVS were women that seemed to have been well functioning before the assault, indicates that the great distress reported in the aftermath of the event was caused mainly by the experience of the sexual assault itself.

The research took place at Copenhagen University Hospital, where the subjects had been treated following the assault and much information was self reported, which implies that the study may be encumbered with information bias. Being at the hospital influenced some of the subjects’ responses, as well as the interviews themselves concerning rape-related problems. Some might have under-reported symptoms as a defence against flashbacks, others might have over-reported because the interview might have triggered aspects of the trauma. Reports may also be coloured by the subjects’
considerations of how they would like to present themselves, and by their imaginations of what was expected from them in the situation.

Alcohol and drugs were involved, which may be a further bias in not getting reliable information, but in fact it is worse, since many participants did not recall what had happened.

In spite of the shortcomings the research contains information of importance in relation to acute consequences of a rape experience.

Limitations of the ASD diagnosis
Most reports tend to treat ASD as ‘provisional PTSD’, meaning that individuals evidence ASD on the way to a formal diagnosis of PTSD (March, 2003).

The diagnosis of ASD arose from a need to assess acute reactions to trauma with a view to prophylactic treatment, in order to prevent posttraumatic consequences of long duration. An important aspect of the ASD diagnosis was therefore its suitability to predict which reactions were prone to develop PTSD.

The ASD diagnosis has been questioned on several points. The duration of ASD is set to be from two days up to a month, but Bryant & Harvey (2002) found that there is no empirical evidence for stating that symptoms present 48 hours after a trauma can differentiate normal reactions from pathological ones. They report several studies indicating that more than half of those suffering from stress symptoms during the first couple of weeks will recover completely during the following months.

The phenomenon of dissociation in ASD can occur during or after the trauma. It does not correspond to the criterion of reactions to last for a minimum of two days. Attention is also drawn to the fact that there is considerable overlap between symptoms of the dissociation cluster (Bryant & Harvey, 2002). McNally (2003, p. 783) has rightly challenged the DSM-IV symptom of amnesia: “The term amnesia presupposes that information has been encoded and the person is unable to access it. If aspects of the traumatic experience were not encoded in the first place, then it is a mistake to say that the person has amnesia for this information”.

Another problem with the ASD diagnosis is that it does not take into account that reactions to stress develop in stages (López-Ibor, 2002) or at different times in different individuals. Even though the questions of the ASD scale are formulated in a way to encompass reactions during the event as well as afterwards, it may be highly significant whether the assessment is made a few days post trauma or some weeks later. One victim of the present study, who was interviewed within the first week post trauma, could not answer the question of whether she had become more aware of dangers
outdoors, because she had not yet been outside. Another woman, who was interviewed during the second week following the assault, said that she had felt quite well during the first week, but when she resumed work, she had a nervous breakdown.

The one-month criterion of ASD is considered too short in relation rape victims. Gilboa-Schectman & Foa (2001) found that recovery was slower in sexual than in non-sexual assault victims. According to studies by Kilpatrick, Veronen & Best (1985) the healing process in rape victims is eighteen months on average. It is the researcher’s experience that it takes about three months for the victim to regain some sort of equilibrium. The victim has to go through all situations of her ordinary daily life with this new experience, in order to be able to relate to the world again (Rust, 2003). She also has to find out what changes may be necessary in relation to herself and in relation to other people. This means that it is not until at least three months after the assault that reactions can be considered as pathological. Thus the distinction between ASD and PTSD after one month seems superfluous. The adequateness of the diagnosis of ASD in assessment of reactions in victims of rape and attempted rape is limited, too, since it does not provide coverage of victims influenced by alcohol and drugs. Neither does the diagnosis encompass frequent acute posttraumatic symptoms as for example feelings of shame, guilt, loss of self-confidence, depressive symptoms, suicidal ideation and psychosomatic symptoms as abdominal pain, headaches, nausea, muscle tensions, and physical exhaustion. Yet, the ASD diagnosis has been employed because it can be used for comparison between acute and long-term reactions, for comparison of the results of the present study with the results of other studies, and because it may be used as a tool in accommodating the acute psychological treatment.

CONCLUSION

The present study indicates that sexual assault must be considered a multifaceted phenomenon, which creates great variation in the traumatised field.

The results of the study confirm other studies demonstrating sexual assault as an extremely stressful experience, causing high degrees of disturbance in the acute aftermath. The most vulnerable victims seem to be adolescent women.

The finding that influence of alcohol/and or drugs during the assault seemed to moderate ASD reactions cannot be taken literally. Other reactions, which have not been examined in the present study, such as blame and shame may be more prominent, if the victim has been under the influence of alcohol/drugs during the rape.
Further studies, also of long-term responses to the assault, are needed to examine the relations found.

The adequateness and necessity of the ASD diagnosis is questionable and in relation to sexual assault further studies are needed to verify its applicability. Yet the fact that it contains such phenomena as dissociation and hyperarousal, found to be prominent in victims of sexual assault, makes the ASD diagnosis look like a promising tool in assessment of acute reactions to sexual assault. In order to prevent or diminish long-term disorders of rape and attempted rape the diagnosis may be useful, both in indicating the importance of offering acute psychological treatment, but also as a tool in tailoring psychological treatment to the needs of the individual, for example inclusion of body therapeutic techniques.

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Long-term Consequences of Sexual Assault: A Follow-up Study

Annalise Rust

Abstract

In order to examine long-term consequences of rape and attempted rape 28 females aged 15-41 years were assessed in relation to Posttraumatic Stress Disorder (PTSD). The assessment was supplemented by including the victims’ self-reports on consequences of the assault experience. The victims had been assessed according to Acute Stress Disorder (ASD) in the immediate aftermath of the assault. A comparison was made between scores of ASD and PTSD. Variables connected to the event and to the individual victim were examined according to PTSD severity.

Results: Criteria of PTSD were met by 71.4% of the victims and according to severity 50% exposed a middle or high degree of PTSD symptoms. The highest correspondence found between scores of ASD and PTSD was on symptoms of arousal and avoidance. Intake of alcohol and/or drugs in the victim before the assault and the age of the victim influenced PTSD, with an intake of alcohol/drugs moderating and young age increasing symptom severity. PTSD severity was also associated with the victims’ reports of physical complaints following the assault, change in eating patterns, self-blame and guilt, and a negative attitude to men and sex.

Key words: Sexual assault, PTSD, self-reported complaints

INTRODUCTION

Development of PTSD is a probable consequence for victims of sexual assault (Bownes, O’Gorman & Sayers, 1991), since sexual assault is a trauma likely to be characterised by both fear of being killed or seriously injured, and also of actually receiving injury (Resnick, Kilpatrick, Dansky, Saunders & Best, 1993).

Studies on reactions to sexual assault, in particular rape and variables influencing reactions are limited in Scandinavia. The present study was carried out to examine the prevalence, character and severity of long-term reactions to rape and attempted rape and to specify possible risk factors of post trauma disturbances.
Predictors of long-term traumatic stress

Traumatic stress reactions of long duration are frequently assessed by employing the diagnosis of Posttraumatic Stress Disorder (PTSD) (American Psychiatric Association, 2000). Studies have found that predictive factors of PTSD may be connected to the traumatic event itself, to the person, who experiences the trauma, and to consequences following the trauma (Freedman, Brandes, Peri & Shalev, 1999).

Factors connected to the trauma
Predictive factors connected to the trauma include involvement of interpersonal violence and the seriousness of the trauma, rape considered most likely to lead to PTSD compared to other traumas (Resnick et al., 1993). A higher prevalence of PTSD has been found in rapes committed by a stranger and in rapes where physical force and weapons have been used, resulting in injuries (Bownes et al., 1991).

Individual psychological characteristics
Subjective measures of distress may be more essential in contributing to PTSD than objective measures of danger (Schore, 1994; Brewin, Andrews, Rose & Kirk, 1999; McNally, 2003). A high correlation has been found between the degrees of danger the individual experiences during the assault and the likelihood of developing PTSD (Bryant, Harvey, Guthrie & Moulds, 2000; 2003; Elsesser, Sartory & Tackenberg, 2004; Nixon, Resick & Griffin, 2004). Fear of dying and losing control may be conceptualised as key cognitive components of panic (Gershuny, Cloitre & Otto, 2003), and death itself may be perceived as the ultimate loss or lack of control (Gershuny & Thayer, 1999).

In victims of sexual assault it has been found that emotional strain, such as feelings of shame and guilt, impede recovery and predict PTSD (Brewin, Andrews & Valentine, 2000; Harvey, Jones & Schmidt, 2003).

Determinants of whether or not an event triggers PTSD may be found in the individual’s prior history of stress experiences, traumas, anxiety and depression, psychiatric disorders, behavioural- and psychological problems and abuse (Wilson, Calhoun & Bernat, 1999; Nishith, Mechanic & Resick, 2000; Hanson, Saunders, Kilpatrick, Resnick, Crouch & Duncan, 2001; Schore, 2001; Vermetten & Bremner, 2002; Nixon et al., 2004).

A family background of psychopathology, especially depressive disorders, has been found predictive of PTSD (Creamer & O’Donnell, 2002; Brewin & Holmes, 2003). Children and adolescents of sexual abuse are more at risk of developing dysfunctions post trauma than adults.
Confidence in one's own abilities to act and change things may play a major role in recovery from trauma (Garber & Seligman, 1980; Antonovsky, 2000). A secure attachment bond in infancy may also function as a primary defence against trauma-induced psychopathology (Stern, 1998; Schore, 2001).

That is to say, that trauma severity, peritraumatic panic (i.e. panic occurring during the trauma), emotional strain, as well as the victim’s age at the time of the trauma, and a prior history of mental loads, seem to be risk factors in relation to development of PTSD.

**Consequences following the trauma**

After a traumatic experience additional stress may follow. A meta-analyses conducted on 14 separate risk factors for PTSD (Brewin et al., 2000) found that factors operating during or after the trauma had stronger effects on development of PTSD than pre-trauma factors. Consequences following trauma may be varied and encompass pain, relocation, loss of job, or reproaches (Brewin et al., 2000; Ozer, Best, Lipsey & Weiss, 2003). For some victims the police interview, the long waiting time before prosecution, and negative reactions from other people may be experienced as retraumatisation (Hazelwood & Burgess, 2001; Rust, 2003; Rust, Jørgensen & Stage, 2003).

Studies indicate that support after trauma has a great impact on recovery (Burgess & Holmstrom, 1974; Dyregrov, 1994; Frazier & Burnett, 1994; Christianson, 1997). Social support not only functions as a buffer, but also has a direct preventive effect on illness (Caplan, 1981; Kessler, Price & Wortman, 1985). Vanderlinden & Vandreuycken (1997) found that individuals who experienced a negative response from the first person they had disclosed the sexual assault to had higher scores of symptoms of PTSD and dissociation.

**ASD in prediction of PTSD**

A meta-analysis of seven predictors of PTSD based on 68 studies suggested that peritraumatic psychological processes are the strongest predictors of PTSD (Ozer et al., 2003). In line with this finding a diagnosis of ASD is assumed to predict PTSD. Prospective studies have indicated that approximately 80% of a population, who meet the criteria for a diagnosis of ASD, develop chronic PTSD (American Psychiatric Association, 2000; Bryant, Moulds & Guthrie, 2000a; March, 2003). In spite of findings of the predictability of ASD there seems, however, to be no linear relationship between acute reactions and PTSD (Bryant, 2003; Yehuda, Bryant, Marmar & Zohar, 2005).
Individuals not meeting the criteria of an ASD diagnosis have turned out later to develop PTSD (Bryant, 2003).

Therapeutic support to people suffering from ASD may significantly reduce the later frequency of PTSD (Foa, Hearst-Ikeda & Perry, 1995; Adshead, 2000; Litz, Gray, Bryant & Adler, 2002; Bryant & Harvey, 2002; Rauch & Cahill, 2003; Moulds & Bryant, 2005). Studies have also found that spontaneous remission during the first months after trauma is high (Rothbaum, Foa, Riggs, Murduch & Walsh, 1992; Feeny, Zoellner & Foa, 2000).

Although studies have validated some factors connected to the time before, during and after the trauma as risk factors in developing PTSD, the picture is so varied, that we may conclude with Fuglsang (2003) that the path to PTSD is individual depending on the presence and absence of a large number of different variables. In some individuals long-term consequences of trauma may not result in PTSD, but in mood- or anxiety disorders (Shear, Zuckoff & Frank, 2001; Southwick, Vythilingam & Charney, 2005). However, as mentioned above, in victims of sexual assault PTSD is frequent (Bownes et al., 1991).

**AIM OF THE STUDY**

To obtain knowledge of long-term consequences of rape or attempted rape a follow-up study was conducted including a group of women, who in the acute aftermath of the assault had been assessed according to the diagnosis of Acute Stress Disorder (ASD) (American Psychiatric Association, 2000). After the assault the women had all gone through psychological treatment at the Centre for Victims of Sexual Assault (CVS), Copenhagen, which is an acute open ward accepting victims of sexual assault for medical and psychosocial examination and treatment. One intention of the follow-up study was to give voice to the victims themselves to learn what might influence long-term distress in victims of sexual assault.

The specific aims were to examine:

- The prevalence and severity of PTSD in victims of rape and attempted rape after psychological treatment.

It was expected that the frequency and severity of post traumatic distress would be significantly reduced in victims diagnosed with ASD in the acute aftermath of the assault corresponding to findings from other studies mentioned above demonstrating remission of traumatic stress symptoms over time and after therapeutic support.
The influence of six variables on long-term posttraumatic stress

The variables were: (1) The woman’s age at the time of the assault; (2) the woman’s intake of alcohol and/or drugs before the assault. If the victim reported an intake of more than five units of alcohol and/or drugs of medium or strong character (e.g. ecstasy, heroin, morphine) before the assault, she was considered to be under the influence of alcohol/drugs (a/d) during the assault. An intake of 0-5 units of alcohol and/or drugs of a mild character (e.g. hashish) before the assault was considered as non-influence of alcohol/drugs (no-a/d) during the assault; (3) the woman’s experience of resistance during the assault (resistance may be verbal and/or physical); (4) the type of assault (rape/attempted rape); (5) violence or threats of violence from the perpetrator (violence covers a spectrum from holding to attempt of strangulation); (6) the kind of relationship between the woman and the perpetrator before the assault.

The same variables had been examined in relation to their influence on development of ASD, where young age was found to increase frequency and severity of ASD, while influence of alcohol or drugs during the assault were found to moderate severity of ASD (Rust, 2008a).

The individual victim’s subjective understanding and conceptualisation of the assault, her reactions to it, and to her life in general.

To supplement assessments of traumatic stress disorder and study reactions to rape as expressed by the victims themselves, *The Copenhagen Rape Experience Interview (CREI)* was designed for the present study.

It was assumed that reactions and adjustment to a sexual assault in the long term would depend on the individual’s appraisal of the event itself and on experiences following the event. That is, cognitive, emotional and existential issues were expected to prevail in long-term adjustment. Self-blame and fear of repetition was expected to be higher in victims influenced by alcohol/drugs during the assault compared to victims not influenced by alcohol or drugs, because intake of alcohol and drugs may have a distorting influence on how people perceive themselves and on how they are perceived by other people.

**POPULATION AND METHODS**

**Participants**

Participants were 28 females recruited from a group of 50 victims of rape (vaginal, oral or anal penetration) and attempted rape (no penetration), which had been assessed in relation to ASD at
CVS within one month following the assault (Rust, 2008a). The 28 participants made up 56% of the original group of 50 females, who were invited for a follow-up interview after an average time of 1.7 years post-assault.

Among the 50 victims invited one had died and two could not be reached. By telephone contact six women reported that they did not want to take part in the follow-up interview because they were afraid of having the assault raked up. Among these, three women felt quite well and the other three women reported that they were still rather affected by the experience.

The differences according to the variables examined between individuals participating in the follow-up study (n=28) and the victims not followed-up (n=22) are shown in Table 1. The subjects who participated in the follow-up study were 21 victims of rape, 3 of attempted rape, and 4 where there was uncertainty concerning penetration.

The largest difference found between the two groups was in relation to intake of alcohol/drugs before the assault, where the victims of the follow-up group more frequently had reported intake of alcohol/drugs (a/d) than the group not followed-up (70.4% vs. 38.1%) (p=0.025).

Table 1. Comparison between victims followed-up and victims not followed-up of the initial study group

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>NO FOLLOW-UP</th>
<th>FOLLOW-UP</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n = 22)</td>
<td>(n = 28)</td>
<td></td>
</tr>
<tr>
<td>Median (25 - 75 percentile) age (years)</td>
<td>21 (18-27)</td>
<td>21 (18-27)</td>
<td>0.970 2</td>
</tr>
<tr>
<td>Alcohol/drugs intake 3</td>
<td>8 (38.1 %)</td>
<td>19 (70.4 %)</td>
<td>0.025</td>
</tr>
<tr>
<td>Type of assault</td>
<td>24</td>
<td></td>
<td>0.250</td>
</tr>
<tr>
<td>Rape (penetration)</td>
<td>14 (73.7 %)</td>
<td>21 (87.5 %)</td>
<td></td>
</tr>
<tr>
<td>Attempted rape</td>
<td>5 (26.3 %)</td>
<td>3 (12.5 %)</td>
<td></td>
</tr>
<tr>
<td>Physical violence 4</td>
<td>17 (77.3 %)</td>
<td>15 (53.6 %)</td>
<td>0.083</td>
</tr>
<tr>
<td>Threats of violence</td>
<td>8 (36.4 %)</td>
<td>3 (10.7 %)</td>
<td>0.030</td>
</tr>
<tr>
<td>Relationship to perpetrator</td>
<td>28</td>
<td></td>
<td>0.680</td>
</tr>
<tr>
<td>Partner/ex-partner</td>
<td>2 (9.5 %)</td>
<td>1 (3.6 %)</td>
<td></td>
</tr>
<tr>
<td>Friend or other acquaintance (&gt; 24 hrs) 5</td>
<td>6 (28.6 %)</td>
<td>8 (28.6 %)</td>
<td></td>
</tr>
<tr>
<td>Occasional acquaintance (&lt; 24 hrs)</td>
<td>5 (23.8 %)</td>
<td>10 (35.7 %)</td>
<td></td>
</tr>
<tr>
<td>Stranger</td>
<td>8 (38.1 %)</td>
<td>8 (28.6 %)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0 (0.0 %)</td>
<td>1 (3.6 %)</td>
<td></td>
</tr>
</tbody>
</table>

1. Chi-square test
2. Mann-Whitney test
3. Alcohol > 5 units and/ or drugs ≥ medium character
4. Physical violence covered a spectrum from holding to attempted strangulation.
5. There is differentiated between perpetrators known more than 24 hours and perpetrators known less than 24 hours.

The victims’ reports of the ASD symptom of dissociative amnesia were registered for comparison in relation to influence of a/d during the assault. Although more participants of the follow-up group
reported intake of a/d before the assault than the group not followed-up, the follow-up group reported less often dissociative amnesia (35.7% vs. 59.1%).

Experienced resistance during the assault was not a database-registered variable at the time of the study: Half of the follow-up group reported active resistance (verbally and/or physically), and the other half reported passive or no resistance during the assault.

All participants had received psychological treatment at CVS following the assault.

Except in relation to a/d and threats of violence there was no significant difference on the other variables compared between the follow-up group and the group that did not to take part in the follow-up study.

**Procedure**

An invitation for a follow-up interview (Appendix F, p.203) was sent to 50 females assessed according to ASD within the first month after a sexual assault. To increase the percentage of participants a second letter was sent (Appendix F, p.204) to those who did not turn up for the interview, with a new suggested time for an interview. This letter also said that if they did not want to participate it would be helpful if they by writing or telephone reported how they felt at this point of time and their reasons for not participating. Independently of participating in the follow-up interview all of the women were offered a session with the psychologist who had treated them. The follow-up interviews were carried out by an assistant, a student of psychology with experience in interviewing. To increase the validity of the study the interviewer had no knowledge of hypotheses or study goals and was instructed in relation to formulation of the introduction and the questions of the instruments. The interviews were standardised and carried out following a plan of questions, but flexibility was allowed to the questions of CREI to get the best flow of the interviews (Thagaard, 2004).

Before accomplishing the interview participants gave informed consent under subject anonymity by signing an agreement of participation. Interviews were carried out January-May 2005 and took place at the hospital where the participants had been treated, but not in the same office. Each interview lasted for about one hour. The individual follow-up interview took place between nine months and 2.3 years after the assault. Mean time was 1.7 years.
Instruments

- The Acute Stress Disorder Scale (ASDS) (Bryant, Harvey, Dang & Sackville, 1998; Bryant & Harvey, 2002) has been used in assessment and analysis of ASD symptoms.

- The Posttraumatic Diagnostic Scale (PDS) in a clinician-administered interview version (Foa, 1995; Foa, Cashman, Jaycox & Perry, 1997) was used in assessment and analysis of PTSD symptoms.

- The Copenhagen Rape Experience Interview (CREI) was used in registration and analysis of self-reports on aspects concerning the individual’s subjective understanding and conceptualisation of the assault, complaints after the assault, and changes in the individual’s life situation and perspective in general.

The Acute Stress Disorder Scale (ASDS)
The ASDS scale (Bryant & Harvey, 2002) was designed to assess a diagnosis of ASD validated against criteria of the Diagnostic and Statistical Manual (4th ed.) (DSM-IV) (American Psychiatric Association, 2000). It consists of nineteen items distributed on four symptom clusters: dissociation (5 items), invasion (4 items), avoidance (4 items), and hyperarousal (6 items). Scores are from 1-5: 1 (not at all), 2 (mildly), 3 (medium), 4 (quite a bit), 5 (very much). Total scores are from 19-95 points. Criteria of ASD of the ASDS scale are a dissociation score ≥ 9 (and a score more than 1 in at least three out of the five symptom items of dissociation) plus a total score ≥ 28 for responses on the other three cluster categories (invasion, avoidance, and hyperarousal) (Bryant & Harvey, 2002).

The Posttraumatic Diagnostic Scale (PDS)
The PDS scale is a brief screening and diagnostic instrument designed to assess the presence and severity of PTSD based on the DSM-IV (Dancu, Riggs, Hearst-Ikeda, Shoyer & Foa, 1996; American Psychiatric Association, 2000) (Appendix B, p.191). The scale has demonstrated high internal consistency and test-reliability, has high agreement with the Structured Clinical Interview for DSM-IV and good sensitivity and specificity (Nishith, Griffin & Poth, 2002). One reason for choosing this scale was that it is validated with rape victims (Dancu et al., 1996; Foa et al., 1997). PTSD is characterised by the reexperiencing of an extremely traumatic event accompanied by avoidance of stimuli associated with the trauma and by symptoms of increased arousal (American Psychiatric Association, 2000). The PDS scale consists of seventeen items distributed on the three PTSD-criteria: reexperiencing (5 items), avoidance (7 items), and arousal (5 items) (Dancu et al.,
Each symptom is rated on a 4-point scale from 0-3: 0 (‘never or only once in a while’), 1 (‘once a week or less/sometimes’), 2 (‘two to four times a week’/’half of the time’), 3 (‘five times a week or more’/’almost always’). Total scores are from 0-51 points. To meet a diagnosis of PTSD demands endorsement (rating of 1 or higher) of at least one reexperiencing symptom, three avoidance symptoms and two arousal symptoms within the last month (Foa et al., 1997). Since the diagnosis of PTSD based on the PDS scale may lead to some individuals’ receiving the diagnosis, even though no symptom is rated at more than 1 and the total score no more than 6, a severity score of PDS has been adopted (Brewin, Andrews & Rose, 2000a). A severity score is attained by summing up all item scores (Dancu et al., 1996). To elucidate differences and similarities in detail between participants according to PTSD the severity score for each participant was calculated. The severity score was employed in evaluation of the influence of six selected variables on PTSD development (Table 3) and in comparison between responses on CREI and PTSD (Table 8).

The Copenhagen Rape Experience Interview (CREI)
The questions of the CREI (Appendix C, p. 195) were designed for the present study. Since the purpose of the diagnoses of ASD and PTSD is to trace and categorise frequent responses to all kinds of traumatic experiences, their suitability is considered limited in providing coverage of the diversity of individual responses to a sexual assault. In order to understand a sexual assault in more detail and in a broader context than attainable through a diagnostic assessment, the CREI was included. The purpose of including the CREI was to give voice to individual conceptions and views on the assault and its consequences, i.e. “to capture the voice of the persons being studied” (Onwuegbuzie & Teddlie, 2003, p. 369).

The questions of CREI deal with aspects, which the researcher from her clinical experience has found of importance to recovery from sexual assault. The construction of the CREI has been inspired by issues found in the Rape Trauma Syndrome (Burgess & Holmstrom; 1974) (Appendix D, p. 199) and in the Comprehensive Sexual Assault Assessment Tool (CSAAT) (Burgess & Hazelwood, 2001). The selection of questions included in the CREI was based on two pilot-studies carried out by the researcher:

- Self-reports of a follow-up interview carried out in 2000 with 8 victims of rape and attempted rape six months post-assault. The participants were interviewed concerning somatic, emotional, cognitive and social complaints (Appendix H, p. 206). They had all attended psychological treatment at CVS (Rust, unpublished pilot study).
A retrospective analysis of the material from the researcher’s psychological records from 2001-2002 of therapy sessions with 154 victims of sexual assault concerning the same issues as in the interview in 2000 (Rust, unpublished pilot study).

The CREI consists of 36 open and closed-ended questions concerning the assault itself and conditions following the assault. Some questions deal with the individual’s experience of support from surroundings and her experience of additional strains following the assault. The victims were asked about individual reactions such as physical complaints included changes in eating habits, thoughts of or attempts of self-mutilation, changes of alcohol and/or medicine or drugs intake and changes of attitudes to oneself and others. Some of the questions of CREI deal with the outcome of psychological treatment and suggestions to improve examination and treatment at CVS. Responses to these questions were not included in the present study.

**Statistical methods**

A registration form for each enquiry to CVS is filled out by the recipient doctor and nurse consisting of sections covering extensive information on the assault, medical treatment, sociodemographics and other relevant information. The information from the registration forms have continuously been transferred to a database created in SPSS for Windows. Based on this general database was drawn the data relevant for the present study, such as information on the assault (rape/attempted rape, physical violence or threats of violence from perpetrator, relationship between victim and perpetrator before the assault, intake of alcohol/drugs before the assault), demographic data (land of origin, age, occupation), personal background data (prior sexual assault, prior psychiatric treatment, chronic illness and abuse of alcohol/drugs). The data were recoded and transferred to a separate database supplemented with scores of the responses to ASDS, PDS, and CREI. The answers of CREI were designed into 36 variables in SPSS, dichotomised into yes/no registration (Nielsen & Kreiner, 1999). This “quantitising” (Teddlie & Tashakkori, 2003) of the mixed data of CREI into numeric codes made a statistical comparative analysis possible with the data from ASDS and PDS. The separate database was used in drawing data for both the initial study on ASD assessment and the present follow-up study. When more than two groups were compared (age groups), Kruskall-Wallis test was used. The SPSS package 11.0 was used for all data analysis. The Pearson Chi-Square test was used to test differences in proportions between groups (Nielsen & Kreiner, 1999; Burns & Bush, 2000). Since the cell sizes were small, Fisher’s exact test was also
used (Rosenthal, Rosnow & Rubin, 2000). As the continuous variables ‘age’ and mean scores of different items and clustered symptoms were not normally distributed, Mann-Whitney test was used to test whether age and mean scores were different between two groups (Burns & Bush, 2000). P-values of ≤ 0.050 were considered statistically significant for the present study.

Associations between scores on the three instruments were examined: The ASDS, the PDS, and the CREI, as well as associations internally among the single items of each of the three instruments. The scores of each instrument were examined in relation to the six variables (age, intake of alcohol/drugs, resistance, rape/attempted rape, violence/threats of violence, and relationship with perpetrator).

RESULTS

Prevalence and severity of PTSD

Criteria of PTSD were met by 20 (71.4%) of the 28 participants, while 8 (28.6%) did not obtain the diagnosis (no-PTSD).

The distribution of mean scores in participants with and without a PTSD diagnosis on each of the three cluster categories of the PDS scale and on each of the seventeen PDS items are shown in Table 2.

Table 2. Median scores (25 - 75 percentile) for three symptom clusters and individual symptoms for participants with and without PTSD

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>PTSD (n = 20)</th>
<th>No PTSD (n = 8)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total PDS</td>
<td>25.0 (15.3 – 33.5)</td>
<td>7.5 (5.3 – 9.8)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Mean Reexperiencing</td>
<td>1.2 (0.5 – 1.7)</td>
<td>0.2 (0.0 – 0.6)</td>
<td>0.004</td>
</tr>
<tr>
<td>Intrusive thoughts / images</td>
<td>2 (1 – 2)</td>
<td>0 (0 – 1)</td>
<td>0.002</td>
</tr>
<tr>
<td>Dreams/nightmares</td>
<td>0 (0 – 2)</td>
<td>0 (0 – 1)</td>
<td>0.220</td>
</tr>
<tr>
<td>Reliving</td>
<td>1 (0 – 1)</td>
<td>0 (0 – 1)</td>
<td>0.110</td>
</tr>
<tr>
<td>Emotionally upset when reminded of the assault</td>
<td>2 (1 – 2)</td>
<td>1 (0 – 1)</td>
<td>0.001</td>
</tr>
<tr>
<td>Physical reactions when reminded of the assault</td>
<td>1 (0 – 2)</td>
<td>0 (0 – 1)</td>
<td>0.160</td>
</tr>
<tr>
<td>Mean Avoidance</td>
<td>1.7 (0.9 – 2.0)</td>
<td>0.2 (0.0 – 0.6)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Of thoughts / conversation / feelings</td>
<td>2 (1 – 3)</td>
<td>0 (0 – 1)</td>
<td>0.004</td>
</tr>
<tr>
<td>Of situations / people / places</td>
<td>2 (0 – 3)</td>
<td>0 (0 – 1)</td>
<td>0.032</td>
</tr>
<tr>
<td>Amnesia</td>
<td>1 (0 – 3)</td>
<td>0 (0 – 1)</td>
<td>0.073</td>
</tr>
<tr>
<td>Lack of interest in activities</td>
<td>1 (0 – 2)</td>
<td>0 (0 – 0)</td>
<td>0.006</td>
</tr>
<tr>
<td>Feeling distant or isolated</td>
<td>2 (1 – 3)</td>
<td>0 (0 – 1)</td>
<td>0.001</td>
</tr>
<tr>
<td>Emotional numbing</td>
<td>1 (1 – 2)</td>
<td>0 (0 – 1)</td>
<td>0.002</td>
</tr>
<tr>
<td>Loss of hope for future</td>
<td>2 (1 – 3)</td>
<td>0 (0 – 1)</td>
<td>0.004</td>
</tr>
<tr>
<td>Mean Arousal</td>
<td>1.5 (1.1 – 2.4)</td>
<td>0.7 (0.5 – 1.0)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Problems with sleeping</td>
<td>0 (0 – 3)</td>
<td>0 (0 – 2)</td>
<td>0.480</td>
</tr>
<tr>
<td>Irritability and anger</td>
<td>2 (1 – 3)</td>
<td>0 (0 – 1)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Concentration difficulties</td>
<td>2 (0 – 3)</td>
<td>1 (0 – 1)</td>
<td>0.048</td>
</tr>
<tr>
<td>Alert response</td>
<td>3 (2 – 3)</td>
<td>1 (0 – 1)</td>
<td>0.001</td>
</tr>
<tr>
<td>Startle response</td>
<td>2 (1 – 3)</td>
<td>1 (0 – 2)</td>
<td>0.260</td>
</tr>
</tbody>
</table>

PTSD = rating ≥ 1 on the three cluster categories (of at least 1 reexperiencing item, 3 avoidance items, 2 arousal items). Scores 0 - 3.
In the PTSD group the mean score was highest in *avoidance* symptoms (1.7) and in the no-PTSD group the mean score was highest in symptoms of *arousal* (0.7). In the PTSD group the highest score on the seventeen individual items was on the *alert response* of the symptom cluster of arousal (3).

**PTSD severity in relation to variables of sexual assault**

Four participants scored 0 on all PDS items and two participants received a PTSD diagnosis with a score as low as 12 (possible range =0-51; actual range= 0-42). In order to estimate the degree of distress more thoroughly in the participants a calculation was made according to severity, dividing the sample into two groups: Those with middle and high PTSD (scores of 18-51) (group I; n=14) and those with none or low PTSD (scores of ≤ 17) (group II; n=14). This scoring method was used to facilitate comparisons in estimating PTSD in relation to the six variables selected in the study. Distribution of scores in relation to the variables is shown in Table 3.

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>n</th>
<th>VICTIMS WITH PDS 18 - 51 (n = 14)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median (25-75 percentile) age (years)</td>
<td>14</td>
<td>20 (18 - 22)</td>
<td>0.160</td>
</tr>
<tr>
<td>Intake of alcohol / drugs ²</td>
<td>13</td>
<td>8 (57.1 %)</td>
<td>0.120</td>
</tr>
<tr>
<td>Type of assault</td>
<td>12</td>
<td></td>
<td>0.540</td>
</tr>
<tr>
<td>Rape (penetration)</td>
<td>11</td>
<td>(91.7 %)</td>
<td></td>
</tr>
<tr>
<td>Attempted rape</td>
<td>1</td>
<td>(8.3 %)</td>
<td></td>
</tr>
<tr>
<td>Physical violence 4</td>
<td>14</td>
<td>7 (50.9 %)</td>
<td>0.710</td>
</tr>
<tr>
<td>Threats of violence</td>
<td>14</td>
<td>1 (7.1 %)</td>
<td>0.540</td>
</tr>
<tr>
<td>Relationship to perpetrator</td>
<td>14</td>
<td></td>
<td>0.580</td>
</tr>
</tbody>
</table>
| Partner/ex-partner                             | 1  | (7.1 %)                           | 0 (0.0 %)
| Friend or other acquaintance (≥ 24 hrs) ³      | 4  | (28.6 %)                          |        |
| Occasional acquaintance (< 24 hrs)            | 6  | (42.9 %)                          |        |
| Stranger                                       | 3  | (21.4 %)                          |        |
| Other                                          | 0  | (0.0 %)                           |        |

1. Chi-square test
2. Mann-Whitney test
3. Alcohol > 5 units and/ or drugs ≥ medium character
4. Physical violence covered a spectre from holding to attempted strangulation.
5. There is differentiated between perpetrators known more than 24 hours and perpetrators known less than 24 hours

There was no difference found between the groups in relation to reported *resistance during the assault* and no significant associations were found between the other five variables examined and PTSD severity, but victims with middle or high PDS score had a lower mean age at the time of the
assault than victims with low PDS scores, while the latter group more frequently reported an intake of alcohol/drugs before the assault.

A comparison on single items of PDS showed that dissociative amnesia was most often found in victims with middle and high PDS scores (50.0% vs. 21.4%). Numbers are small for a comparison, but assaults by a stranger were most frequently found in the group with low PDS scores (35.7% vs. 21.4%), while assaults by an occasional acquaintance were more frequent in victims with PDS scores of 18-51 (42.9% vs. 28.6%). The results thus indicate that young age at the time of a sexual assault may increase the severity of post traumatic distress, while intake of alcohol/drugs before the assault may have a moderating influence on severity of reactions post trauma. In order to verify these findings, an examination was made between scores on individual items of PDS and the variables age and intake of alcohol/drugs before the assault. The results are described in Tables 4-6.

PTSD severity and age
Participants below 25 years of age at the time of the assault reported the most severe long-term trauma reactions. Mean scores according to age on cluster categories and individual symptoms of PDS are shown in Table 4.

Table 4. Median PDS scores (25 – 75 percentile) by age group

<table>
<thead>
<tr>
<th>SYMPTOM</th>
<th>15 - 17 YEARS (n = 7)</th>
<th>18 - 19 YEARS (n = 6)</th>
<th>20 - 24 YEARS (n = 8)</th>
<th>25 - 41 YEARS (n = 7)</th>
<th>p1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total PDS</td>
<td>22 (13 – 32)</td>
<td>30 (15 – 37)</td>
<td>19 (12 – 29)</td>
<td>9 (6 – 15)</td>
<td>0.050</td>
</tr>
<tr>
<td>Mean reexperiencing</td>
<td>1.2 (0.6 – 1.2)</td>
<td>1.6 (0.9 – 2.4)</td>
<td>0.6 (0.2 – 1.4)</td>
<td>0.4 (0.0 – 0.6)</td>
<td>0.020</td>
</tr>
<tr>
<td>Intrusive thoughts/ images</td>
<td>1 (0 – 2)</td>
<td>2 (1 – 3)</td>
<td>2 (0 – 2)</td>
<td>0 (0 – 1)</td>
<td>0.120</td>
</tr>
<tr>
<td>Dreams/nightmares</td>
<td>1 (0 – 1)</td>
<td>2 (1 – 3)</td>
<td>0 (0 – 0)</td>
<td>0 (0 – 0)</td>
<td>0.096</td>
</tr>
<tr>
<td>Reliving</td>
<td>1 (0 – 1)</td>
<td>1 (0 – 2)</td>
<td>0 (0 – 1)</td>
<td>0 (0 – 1)</td>
<td>0.240</td>
</tr>
<tr>
<td>Emotionally upset</td>
<td>1 (1 – 2)</td>
<td>2 (2 – 2)</td>
<td>1 (1 – 2)</td>
<td>1 (0 – 1)</td>
<td>0.019</td>
</tr>
<tr>
<td>Physical reactions</td>
<td>1 (1 – 1)</td>
<td>2 (0 – 2)</td>
<td>0 (0 – 1)</td>
<td>0 (0 – 1)</td>
<td>0.032</td>
</tr>
<tr>
<td>Mean avoidance</td>
<td>1.9 (0.7 – 2.1)</td>
<td>1.6 (0.7 – 1.9)</td>
<td>1.4 (0.6 – 1.9)</td>
<td>0.4 (0.1 – 0.9)</td>
<td>0.110</td>
</tr>
<tr>
<td>Of thoughts/conversation/ feelings</td>
<td>3 (2 – 3)</td>
<td>3 (2 – 3)</td>
<td>2 (0 – 3)</td>
<td>0 (0 – 1)</td>
<td>0.014</td>
</tr>
<tr>
<td>Of situations/people/places</td>
<td>3 (0 – 3)</td>
<td>1 (0 – 3)</td>
<td>1 (0 – 2)</td>
<td>0 (0 – 1)</td>
<td>0.190</td>
</tr>
<tr>
<td>Amnesia</td>
<td>0 (0 – 1)</td>
<td>1 (0 – 3)</td>
<td>1 (0 – 3)</td>
<td>0 (0 – 2)</td>
<td>0.940</td>
</tr>
<tr>
<td>Lack of interest in activities</td>
<td>1 (0 – 2)</td>
<td>1 (0 – 1)</td>
<td>1 (0 – 2)</td>
<td>0 (0 – 0)</td>
<td>0.024</td>
</tr>
<tr>
<td>Feeling distant or isolated</td>
<td>2 (0 – 2)</td>
<td>2 (1 – 2)</td>
<td>2 (0 – 3)</td>
<td>1 (0 – 1)</td>
<td>0.200</td>
</tr>
<tr>
<td>Emotional numbing</td>
<td>1 (0 – 2)</td>
<td>1 (1 – 2)</td>
<td>1 (0 – 2)</td>
<td>1 (0 – 2)</td>
<td>0.600</td>
</tr>
<tr>
<td>Loss of hope for future</td>
<td>1 (1 – 2)</td>
<td>2 (1 – 2)</td>
<td>2 (0 – 3)</td>
<td>1 (0 – 2)</td>
<td>0.390</td>
</tr>
<tr>
<td>Mean arousal</td>
<td>1.4 (0.6 – 2.2)</td>
<td>1.7 (1.2 – 2.6)</td>
<td>1.2 (1.0 – 2.2)</td>
<td>0.8 (0.4 – 1.0)</td>
<td>0.060</td>
</tr>
<tr>
<td>Problems with sleeping</td>
<td>0 (0 – 2)</td>
<td>2 (0 – 3)</td>
<td>0 (0 – 2)</td>
<td>0 (0 – 1)</td>
<td>0.550</td>
</tr>
<tr>
<td>Irritability and anger</td>
<td>2 (1 – 3)</td>
<td>2 (1 – 2)</td>
<td>1 (1 – 3)</td>
<td>0 (0 – 1)</td>
<td>0.051</td>
</tr>
<tr>
<td>Concentration difficulties</td>
<td>2 (0 – 3)</td>
<td>2 (1 – 2)</td>
<td>2 (0 – 2)</td>
<td>0 (0 – 1)</td>
<td>0.110</td>
</tr>
<tr>
<td>Alert response</td>
<td>2 (1 – 3)</td>
<td>3 (2 – 3)</td>
<td>3 (1 – 3)</td>
<td>1 (1 – 2)</td>
<td>0.600</td>
</tr>
<tr>
<td>Startle response</td>
<td>1 (1 – 2)</td>
<td>3 (1 – 3)</td>
<td>1 (1 – 3)</td>
<td>1 (0 – 2)</td>
<td>0.780</td>
</tr>
</tbody>
</table>

1. Kruskall Wallis test
Overall the age group of 25-41 years old exhibited the fewest symptoms of PTSD compared to victims below 25 years of age. The age group of 18-19 years old had the highest total PDS score. A comparison on individual PTSD symptoms shows that the youngest (the 15-17 years old) and the age group above 25 years had a lower mean score on the symptoms of alert response, loss of hope for future and intrusive thoughts/images than the age groups 18-24 years. Furthermore it was found that the youngest (the 15-17 years old) had the highest mean score on the symptom of avoidance of situations/people/places. The findings seem to confirm that young age at the time of the assault may increase the risk of severe posttraumatic distress with the greatest risk found for 18-19 years old participants in the present study.

PTSD severity and intake of alcohol and/or drugs before the assault
More than two thirds of the participants, 19 (67.9%), had been under the influence of alcohol/drugs during the assault, and this group had a considerably lower total PDS score (15.0) than the no-a/d group (29.5).

Mean scores of PDS in relation to intake of a/d are shown in Table 5.

<table>
<thead>
<tr>
<th>ITEMS OF PDS</th>
<th>INTAKE OF A/D (n=19)</th>
<th>NO INTAKE OF A/D (n=8)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total PDS</td>
<td>15.0 (12.0 – 25.0)</td>
<td>29.5 (12.5 – 38.0)</td>
<td>0.152</td>
</tr>
<tr>
<td>Reexperiencing mean</td>
<td>0.6 (0.4 – 1.2)</td>
<td>1.6 (0.7 – 2.4)</td>
<td>0.023</td>
</tr>
<tr>
<td>Intrusive thoughts/images</td>
<td>1 (0 – 2)</td>
<td>2 (1 – 3)</td>
<td>0.140</td>
</tr>
<tr>
<td>Dreams/ nightmares</td>
<td>0 (0 – 1)</td>
<td>2 (0 – 3)</td>
<td>0.006</td>
</tr>
<tr>
<td>Reliving</td>
<td>0 (0 – 1)</td>
<td>1 (1 – 2)</td>
<td>0.005</td>
</tr>
<tr>
<td>Emotionally upset when reminded of the assault</td>
<td>1 (1 – 2)</td>
<td>2 (1 – 3)</td>
<td>0.071</td>
</tr>
<tr>
<td>Physical reactions when reminded of the assault</td>
<td>0 (0 – 1)</td>
<td>1 (0 – 2)</td>
<td>0.091</td>
</tr>
<tr>
<td>Avoidance mean</td>
<td>0.8 (0.6 – 1.9)</td>
<td>1.6 (0.6 – 1.8)</td>
<td>0.600</td>
</tr>
<tr>
<td>Of thoughts/ conversation/ feelings</td>
<td>2 (0 – 3)</td>
<td>3 (1 – 3)</td>
<td>0.280</td>
</tr>
<tr>
<td>Of situations/ people/places</td>
<td>0 (0 – 2)</td>
<td>2 (0 – 3)</td>
<td>0.140</td>
</tr>
<tr>
<td>Amnesia</td>
<td>1 (0 – 2)</td>
<td>1 (0 – 2)</td>
<td>0.790</td>
</tr>
<tr>
<td>Lack of interest in activities</td>
<td>0 (0 – 2)</td>
<td>1 (0 – 1)</td>
<td>0.880</td>
</tr>
<tr>
<td>Feeling distant or isolated</td>
<td>1 (0 – 2)</td>
<td>2 (0 – 2)</td>
<td>0.740</td>
</tr>
<tr>
<td>Emotional numbing¹</td>
<td>1 (0 – 2)</td>
<td>1 (0 – 2)</td>
<td>0.560</td>
</tr>
<tr>
<td>Loss of hope for future</td>
<td>1 (1 – 3)</td>
<td>2 (0 – 3)</td>
<td>0.740</td>
</tr>
<tr>
<td>Arousal mean</td>
<td>1.2 (1.0 – 1.8)</td>
<td>1.9 (0.9 – 2.6)</td>
<td>0.160</td>
</tr>
<tr>
<td>Problems with sleeping</td>
<td>0 (0 – 2)</td>
<td>2 (0 – 3)</td>
<td>0.150</td>
</tr>
<tr>
<td>Irritability and anger</td>
<td>1 (1 – 2)</td>
<td>2 (0 – 3)</td>
<td>0.560</td>
</tr>
<tr>
<td>Concentration difficulties</td>
<td>1 (0 – 2)</td>
<td>2 (0 – 3)</td>
<td>0.460</td>
</tr>
<tr>
<td>Alert response</td>
<td>2 (1 – 3)</td>
<td>3 (1 – 3)</td>
<td>0.400</td>
</tr>
<tr>
<td>Startle response</td>
<td>1 (1 – 2)</td>
<td>2 (1 – 3)</td>
<td>0.097</td>
</tr>
</tbody>
</table>

1. Intake of A/D = Alcohol > 5 units/drugs medium or strong character (e.g. ecstasy, heroin, morphine).
   No intake of A/D = Alcohol ≤ 5 units/drugs mild character (e.g. hashish).
The largest difference between the two groups was on the symptom cluster of reexperiencing, where the a/d group had a mean score of 0.6, while the no-a/d group had a mean score of 1.6 (p = 0.023). Within both groups the highest mean score was reported on the symptom cluster of arousal. In 15 of the 17 individual items of PDS did the no-a/d group have a higher mean score than the a/d group. In the avoidance symptoms of amnesia and emotional numbing both group had a mean score of 1. The findings seem to confirm that intake of alcohol/drugs before the assault may have a moderating influence on development of posttraumatic distress.

The examination of the six variables selected as possible predictors of severity of PTSD responses thus indicated, that two of the variables seemed to have an influence: age and intake of alcohol/drugs before the assault, where young age at the time of the assault seemed to increase the risk of PTSD severity, while intake of alcohol/drugs seemed to have a moderating influence on PTSD severity.

**Coincidence between ASD and PTSD**

While 92.9% of the 28 participants had been assessed initially as suffering from ASD, the percentage diagnosed with PTSD in the follow-up study was 71.4%. Two participants in the study of acute reactions (Rust, 2008a), who did not meet the diagnosis of ASD, took part in the follow-up interview, and they had not developed PTSD either.

Comparative analyses were made between scores on 14 questions of ASDS and PDS, which were directly comparable within the two scales (Table 6) in order to examine which symptoms might be the most distressful in the long-term for the participants. Since three avoidance items of ASDS (avoidance of thoughts, conversation, and feelings) are combined into one item in PDS a mean score of the ASDS scores on the three items was calculated. To assess degree of severity of symptoms in the follow-up and ease comparison only the highest scores of ASDS (scores 4 and 5) and PDS (scores 3 and 4) of the 28 participants in both studies were counted. The PDS avoidance symptoms, amnesia and emotional numbing, were compared to the dissociation symptoms of ASDS, since the terms designate the same symptoms.
Table 6. Coincidence between ASDS scores (4 and 5) and PDS scores (2 and 3)

<table>
<thead>
<tr>
<th>SYMPTOM</th>
<th>COINCIDENCE BETWEEN ASDS AND PDS SCORES¹</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n = 28)</td>
</tr>
<tr>
<td><strong>Dissociation</strong></td>
<td></td>
</tr>
<tr>
<td>Emotional numbing</td>
<td>7 (25.0 %)</td>
</tr>
<tr>
<td>Amnesia (n=27)</td>
<td>6 (22.2 %)</td>
</tr>
<tr>
<td><strong>Reexperiencing</strong></td>
<td></td>
</tr>
<tr>
<td>Intrusive thoughts/ images</td>
<td>6 (21.4 %)</td>
</tr>
<tr>
<td>Dreams/nightmares</td>
<td>3 (10.7 %)</td>
</tr>
<tr>
<td>Reliving</td>
<td>3 (10.7 %)</td>
</tr>
<tr>
<td>Emotionally upset</td>
<td>5 (17.9 %)</td>
</tr>
<tr>
<td>Physical reactions</td>
<td>3 (10.7 %)</td>
</tr>
<tr>
<td><strong>Avoidance</strong></td>
<td></td>
</tr>
<tr>
<td>Of thoughts/conversation/feelings</td>
<td>14 (50.0 %)</td>
</tr>
<tr>
<td>Of situations/people/places</td>
<td>7 (25.0 %)</td>
</tr>
<tr>
<td><strong>Arousal</strong></td>
<td></td>
</tr>
<tr>
<td>Problems with sleeping</td>
<td>6 (21.4 %)</td>
</tr>
<tr>
<td>Irritability and anger</td>
<td>8 (28.6 %)</td>
</tr>
<tr>
<td>Concentration difficulties</td>
<td>11 (39.3 %)</td>
</tr>
<tr>
<td>Alert response</td>
<td>13 (46.4 %)</td>
</tr>
<tr>
<td>Startle response</td>
<td>9 (32.1 %)</td>
</tr>
</tbody>
</table>

¹. ASDS: 4 = quite a bit; 5 = very much; PDS = two to four times a week / half of the time; 3 = five or more times a week / almost always

The highest correspondence found between scores of ASDS and PDS were on symptoms of avoidance and arousal. Half of the women of the follow-up survey reported that they several times a week tried to avoid being affected by the assault (avoidance of thoughts/conversation/feelings), and a large number of victims still suffered from a high degree of psychophysiological complaints: Increased alertness (46.4%), concentration difficulties (39.3%), and startle response (32.1%). Symptoms of arousal and avoidance were thus found to be persistent long-term consequences for several of the victims examined in the present studies, while symptoms of dissociation and re-experiencing had been considerably reduced in most of the participants.

CREI: Individual Self-reported experiences

The Copenhagen Rape Experience Interview (CREI) (Appendix C, p. 195) was used to examine self-reported experiences concerning aspects considered to have an impact on reactions following a sexual assault. Open-ended questions involve victims’ reports on causes for the rape coming about and their views of the worst aspects of the sexual assault.
Reported causes for rape
The victims were asked what causes they saw for the rape coming about. Several causes were reported, but 16 victims (57.1%) reported as the main cause the fact that they had been alone. Intake of alcohol and/or drugs before the assault in victim and/or perpetrator was reported as the cause for the rape by 12 victims (42.9%). A statistical analysis of relations between items of the CREI showed a relation between reports of being alone and influence of a/d in the perpetrator as underlying the rape (p= 0.020). Both causes for the rape coming about were reported in 10 participants (62.5%).

The worst aspect of the experience
Several things were reported to the question of CREI concerning the worst aspect of the experience. Most often the aspects reported were connected to the perpetrator or to the victim herself. In relation to the perpetrator the worst things mentioned concerned feelings of humiliation, of not being respected, his use of power and force, desertion, invasion of privacy, and flashbacks. The worst personal things mentioned were self-blame for not being able to prevent the assault, helplessness, lack of resistance, loss of control, and feelings of guilt and shame.

In Table 7 an overview is given of the participants’ reports of closed-ended items of CREI assumed to influence consequences of a sexual assault experience.
### Table 7. Frequency of self-reports on selected items of CREI

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>PARTICIPANTS (n = 28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Items of CREI</td>
<td>n (%)</td>
</tr>
<tr>
<td>Afraid of being beaten</td>
<td>12 (42.9 %)</td>
</tr>
<tr>
<td>Threat to life</td>
<td>12 (42.9 %)</td>
</tr>
<tr>
<td>Afraid of dying</td>
<td>15 (53.6 %)</td>
</tr>
<tr>
<td>Support from network</td>
<td>22 (78.6 %)</td>
</tr>
<tr>
<td>Mother very / moderately caring as a parent</td>
<td>25 (89.3 %)</td>
</tr>
<tr>
<td>Farther very / moderately caring as a parent</td>
<td>18 (64.3 %)</td>
</tr>
<tr>
<td>Other strains than the assault</td>
<td>25 (89.3 %)</td>
</tr>
<tr>
<td>Police report stressful</td>
<td>15 (78.9 %)</td>
</tr>
<tr>
<td>Medical / forensic examination stressful</td>
<td>10 (35.7 %)</td>
</tr>
<tr>
<td>Pressure of work / exam stressful</td>
<td>20 (71.4 %)</td>
</tr>
<tr>
<td>Reactions from people stressful</td>
<td>16 (57.1 %)</td>
</tr>
<tr>
<td>Self-blame / guilt</td>
<td>17 (60.7 %)</td>
</tr>
<tr>
<td>Change in attitudes from others</td>
<td>14 (50.0 %)</td>
</tr>
<tr>
<td>Change in eating habits</td>
<td>15 (53.6 %)</td>
</tr>
<tr>
<td>Prior eating problems</td>
<td>13 (46.4 %)</td>
</tr>
<tr>
<td>Increase in alcohol intake</td>
<td>3 (10.7 %)</td>
</tr>
<tr>
<td>Increase in drug intake</td>
<td>5 (17.9 %)</td>
</tr>
<tr>
<td>Physical complaints</td>
<td>14 (50.0 %)</td>
</tr>
<tr>
<td>Isolation</td>
<td>22 (78.6 %)</td>
</tr>
<tr>
<td>Self-mutilation</td>
<td>16 (57.2 %)</td>
</tr>
<tr>
<td>Thoughts</td>
<td>9 (32.1 %)</td>
</tr>
<tr>
<td>Attempt</td>
<td>7 (25.0 %)</td>
</tr>
<tr>
<td>More negative attitude to men and sex</td>
<td>18 (64.3 %)</td>
</tr>
</tbody>
</table>

1. 19 reported to the police, and 15 of these (78.9 %) found the report stressful.
2. Coincidence with prior eating problems in 8 cases. In 2 cases the eating pattern had improved.
3. In 2 cases increase in pain relieving medicine.

### Fear of violence and death

Twelve victims (42.9%) reported having been afraid of being beaten. A little more than half of the participants, 15 (53.6%), reported having been afraid of dying, and 12 (42.9%), had experienced the assault as a threat to life.

A relation was found between the 12 participants who reported being afraid of being beaten and the 12 who reported that they had felt that their life was threatened. Nine of them reported both (p = 0.010).

The women who had felt that their life was threatened had also been afraid of dying, 10 (of 12) (p = < 0.001).
Support from network
The victims were asked if they felt, that they had received the support they needed from families and others, and 22 participants (78.6%) confirmed this. Most of the victims reported support from family, but three of them from friends only. The question was not specified, so it could be understood as social support in general or concerning the time after the assault.

The participants were also asked how they felt their parents altogether had been towards them: Very caring, moderately caring or not caring. In relation to the mother, 25 victims (89.3%), experienced her as very/moderately caring, and in relation to the father, 18 victims (64.3%) had the same experience. Two women had no contact to their father.

Consequences following the assault
The participants reported that the assault had influenced their lives and well-being in several respects:

In the aftermath of the assault almost all of the victims had experienced other strains than the assault. The three most stressful areas reported were police report, pressure of work or exam and reactions from people around. Nineteen victims reported the assault to the police, but only 4 of these cases (21%) lead to prosecution.

Most of the victims felt isolated after the assault, and two thirds reported a negative attitude towards men and sex. Self-blame and feelings of guilt for the assault coming about were reported by more than half of the victims. Changes in eating habits and attempts of, or thoughts of self-mutilation, were also reported by more than 50%. Half of the victims reported physical complaints non-observed before the assault, and none of these had been under the influence of alcohol/drugs during the assault.

The results of the CREI interview indicated that the sexual assault had resulted in extensive and profound distress for the victims.

Relations between PTSD severity and CREI
A comparison was made between scores of the 17 PDS items and 36 items of the CREI. The distribution of responses of CREI relevant for the present study in relation to severity of PTSD is shown in Table 8.
Table 8. Distribution of responses on items of CREI in relation to severity of PTSD

<table>
<thead>
<tr>
<th>ITEMS OF CREI</th>
<th>GROUP I VICTIMS WITH MIDDLE OR HIGH PDS SCORES (18 - 51) (n = 14)</th>
<th>GROUP II VICTIMS WITH NONE OR LOW PDS SCORES (0 ≤ 17) (n = 14)</th>
<th>P²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afraid of being beaten</td>
<td>7 (50.0 %)</td>
<td>5 (35.7 %)</td>
<td>0.700</td>
</tr>
<tr>
<td>Threat to life</td>
<td>6 (42.9 %)</td>
<td>6 (42.9 %)</td>
<td>1.000</td>
</tr>
<tr>
<td>Afraid of dying</td>
<td>8 (57.1 %)</td>
<td>7 (50.0 %)</td>
<td>1.000</td>
</tr>
<tr>
<td>Support from network</td>
<td>9 (64.3 %)</td>
<td>13 (92.9 %)</td>
<td>0.170</td>
</tr>
<tr>
<td>Mother very / moderately caring as a parent</td>
<td>12 (85.7 %)</td>
<td>13 (92.9 %)</td>
<td>0.995</td>
</tr>
<tr>
<td>Father very / moderately caring as a parent</td>
<td>8 (57.1 %)</td>
<td>10 (71.4 %)</td>
<td>0.700</td>
</tr>
<tr>
<td>Other strains than the assault</td>
<td>14 (100.0 %)</td>
<td>11 (78.6 %)</td>
<td>0.220</td>
</tr>
<tr>
<td>Police report stressful²</td>
<td>8 (57.1 %)</td>
<td>7 (50.0 %)</td>
<td>0.995</td>
</tr>
<tr>
<td>Medical / forensic examination stressful</td>
<td>3 (21.4 %)</td>
<td>7 (50.0 %)</td>
<td>0.240</td>
</tr>
<tr>
<td>Pressure of work / exam stressful</td>
<td>11 (78.6 %)</td>
<td>9 (64.3 %)</td>
<td>0.680</td>
</tr>
<tr>
<td>Reactions from people stressful</td>
<td>9 (65.3 %)</td>
<td>7 (50.0 %)</td>
<td>0.700</td>
</tr>
<tr>
<td>Self-blame / guilt</td>
<td>12 (85.7 %)</td>
<td>5 (35.7 %)</td>
<td>0.018</td>
</tr>
<tr>
<td>Change in attitudes from others</td>
<td>7 (50.0 %)</td>
<td>7 (50.0 %)</td>
<td>1.000</td>
</tr>
<tr>
<td>Change in eating habits³</td>
<td>11 (78.6 %)</td>
<td>4 (28.6 %)</td>
<td>0.018</td>
</tr>
<tr>
<td>Prior eating problems</td>
<td>7 (50.0 %)</td>
<td>6 (42.9 %)</td>
<td>0.995</td>
</tr>
<tr>
<td>Increase in alcohol intake</td>
<td>1 (7.1 %)</td>
<td>2 (14.3 %)</td>
<td>0.995</td>
</tr>
<tr>
<td>Increase in drug intake⁴</td>
<td>4 (28.6 %)</td>
<td>0 (0.0 %)</td>
<td>0.100</td>
</tr>
<tr>
<td>Physical complaints</td>
<td>12 (85.7 %)</td>
<td>2 (14.3 %)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Isolation</td>
<td>12 (85.7 %)</td>
<td>10 (71.4 %)</td>
<td>0.650</td>
</tr>
<tr>
<td>Self-mutilation</td>
<td>9 (64.3 %)</td>
<td>7 (50.0 %)</td>
<td>0.700</td>
</tr>
<tr>
<td>Thoughts</td>
<td>4 (28.6 %)</td>
<td>5 (35.7 %)</td>
<td>0.980</td>
</tr>
<tr>
<td>Attempt</td>
<td>5 (35.7 %)</td>
<td>2 (14.3 %)</td>
<td>0.390</td>
</tr>
<tr>
<td>Negative attitude to men and sex</td>
<td>12 (85.7 %)</td>
<td>6 (42.9 %)</td>
<td>0.050</td>
</tr>
</tbody>
</table>

1. Fisher’s exact test
2. 9 reported to the police, and 15 of these (78.9 %) found the report stressful.
3. Coincidence with prior eating problems in 8 cases. In 2 cases the eating pattern had improved.
4. In 2 cases increase in pain relieving medicine.

The strongest association found in the survey was between moderate/high scores of PDS (Group I) and self-reports of CREI concerning physical complaints (p= <0.001): 85.7% of Group I reported physical complaints non-observed before the assault versus 21.4% of Group II (none or low PDS scores), and none of them had been under the influence of alcohol/drugs during the assault.

An association was also found between severity of PDS scores and change in eating habits (p= 0.018), self-blame/guilt (p= 0.018) and a negative attitude to men and sex (p=0.050) after the assault, reported by a larger number of Group I than of Group II.

The results of the CREI interview indicated that intake of alcohol/drugs and ‘being alone’ were risk factors for the assault coming about. The victims reported feeling deeply humiliated by the assault.
and were blaming themselves for not being able to prevent it. In the aftermath most of the victims had experienced support from their networks, but in spite of that a great deal of them felt that the sexual assault had reduced their quality of life and standard of health.

DISCUSSION

Discussion of the results of the study

The aim of the present study was to obtain knowledge of long-term consequences of a sexual assault.

1. It was assumed that frequency and severity of posttraumatic distress would be considerably reduced in the participants of the present study compared to the reactions found in the immediate aftermath of the assault.

2. It was of interest to examine the influence of six selected variables on long-term posttraumatic stress to see if the influence found in the acute aftermath of the assault would be found in the long term as well.

3. It was assumed that the individual’s appraisal of the assault and experiences following the event would have an impact on her long-term reactions and adjustment. Victims under the influence of alcohol/drugs during the assault were expected to report self-blame and fear of repetition more frequently than victims not influenced by alcohol or drugs.

PTSD after psychological treatment

Studies have demonstrated remission of traumatic stress symptoms over time and after therapeutic support. Thus it was expected that the frequency and severity of PTSD in the present study would be significantly reduced compared to scores of ASD. Yet, long-lived and extensive consequences are frequently found in rape, which is considered to be the trauma most likely to lead to PTSD (Resnick et al., 1993). The present study confirmed these findings: The prevalence of PTSD among participants, compared to prevalence of ASD, had decreased, and in severity half of the 28 participants reported symptoms of PTSD to a mild degree only within the last month before the follow-up interview. Still, although psychological treatment was set in immediately following the sexual assault, the prevalence and severity of PTSD was considerable. Comparison with non-treated individuals was not made in the present study, so the findings may be regarded as both positive and negative: Positive in the way that post trauma suffering had decreased, but negative in the way that a single psychological trauma in so many may be experienced as highly problematic when you are
reminded of it even years after. The high frequency and severity of PTSD also necessitates that possible weaknesses and insufficiencies of the psychological treatment are brought into focus.

**ASD as a predictor of PTSD**
The most frequent and severe PTSD symptoms found in the present study were symptoms of avoidance and arousal, even in victims who did not meet the criteria of PTSD. The same symptoms had been found in the ASD assessment. The result seems to confirm findings from other studies indicating that a diagnosis of ASD is predictive of chronic PTSD (i.e. PTSD lasting for more than 3 months) (American Psychiatric Association, 2000). The result also seems to confirm findings indicating that panic (i.e. symptoms of dissociation and arousal) and phobic fear reactions (avoidance) in the acute aftermath of a traumatic event are risk factors of PTSD (Brewin et al., 1999; Bryant et al., 2003; Ozer et al., 2003; Schell, Marshall & Jaycox, 2004), frequently resulting in a persistence of these symptoms over time in rape victims (Burgess & Holmstrom, 1974; Rothbaum et al., 1992; Dahl, 1993; Foa, Riggs & Gershuny, 1995; Falsetti & Resnick, 1997; Nixon et al., 2004).

Symptoms of arousal as manifestations of fear and anxiety are psychophysiological in nature, and may be considered as learned alarms according to classical conditioning theories (Falsetti, Resnick, Dansky, Lydiard & Kilpatrick, 1995; Falsetti & Resnick, 1997; Gershuny & Thayer, 1999). These theories propose that panic attacks can become a conditioned response to trauma related cues and generalise in trauma victims with PTSD. The high prevalence of arousal and avoidance responses found in the present study seem to confirm this generalisation of a peritraumatic panic attack.

**Coping with fear**
The symptoms of avoidance and arousal found in the present study correspond to what is termed as the flight-fight-‘freezing’- response, which may be elicited by exposure to extreme stress (Christianson, 1997; van der Kolk, 1996; Barlow, 2004). Being exposed to a trauma may be experienced as a life-threatening situation forming a fear network (Foa et al., 1992). When the fear network is activated the person becomes hypervigilant (arousal in PTSD) (Barlow, 2004) and attempts to prevent triggering of alarms (avoidance in PTSD) by avoiding and suppressing emotions, as well as avoiding external trauma-related stimuli (Brewin & Holmes, 2003). One 16 years old rape victim spontaneously compared herself to a deer, all the time ready to make off. Before the rape she would have grumbled and objected, if someone offended her, but now she had become too scared. Avoidance may thus be seen as a coping strategy, a psychological defence
mechanism brought into play to avoid memories of the trauma (Hilgard, 1977). However, this emotionally focused coping (Lazarus, 1993) is considered unhelpful for the majority of trauma victims (Garber & Seligman, 1980; Brewin & Holmes, 2003; Antonovsky, 2000). Prospective studies have indicated that avoidance and thought suppression are related to a slower recovery from PTSD (Janoff-Bulman, 1992; Horowitz, 1997; Roemer, Orsillo, Borkovec & Litz, 1998). Higher levels of arousal, which mean the individual’s experience of not being in control during and after the traumatic event, seem to cause higher levels of distress (Gershuny & Thayer, 1999). One example was a 27 years old well functioning university student, who had been seized from behind and raped by an unknown man. She was very fond of sport, challenging physical limits. She had not resisted the man because she had felt that her life was in danger. After the rape she was full of self-blame and guilt. Her reactions during the rape fitted in poorly with her self-image of being in control mentally as well as physically. Thus, she had chosen to ‘forget’ the rape and instead concentrate fully on intellectual subjects, which was simple at a mental level, since the rape seemed unreal to her like a dream. The woman ended therapy after a few sessions, but after the follow-up interview she accepted psychological contact realising that she needed professional help to overcome the severe problems she was still suffering from.

Thus, the tendency for participants in the present study seemed to be adaptation of such behavioural strategies of survival, where they consciously and unconsciously tried to suppress thoughts and avoid trauma reminders to minimise fear and anxiety.

Variables influencing long-term adjustment
Young age was found to be a risk factor of PTSD severity, while influence of alcohol and/or drugs during the assault seemed to moderate response severity. There were no relations found between PTSD and the four other variables examined. The findings of the present study on long-term reactions thus correspond to the findings of the study on acute reactions to a sexual assault (Rust, 2008a). A higher prevalence of PTSD has been found in other studies of rapes committed by a stranger and in rapes where physical force and weapons have been used (Bownes et al., 1991; Resnick et al., 1993). The present study could not confirm such a relation.

The risk by being young
The severity of PTSD was highest in victims below 25 years of age, which may reflect that coping capacity and variability in behaviour strategies are strengthened by life experience (Janoff-Bulman, 1992). More behaviour of avoidance and isolation was found in the group of 15-24 years old. This implies that a young person following a sexual assault is at risk of being isolated from the peer-
group, which in youth serves as an important arena for socialisation (Winnicott, 1974). The younger the victim is, the less developed are the mechanisms of defence and coping that are activated by the trauma. Following a sexual assault the risk of developing a negative self-image can be great (Zinkin, 1985; Nitsun, 1991). One 15 years old said that she considered herself as yukky and understood quite well, if her friends kept her at a distance. Emotionally young victims of rape have difficulty in coming to terms with the experience; they do not know their feelings well enough and do not have sufficient verbally concepts to express how they feel (Piaget & Inhelder, 1971). Neither do they understand fully the meaning of what they have been exposed to. The youngest victims (the 15-17 years old) also reported less alertness than the age group of 18-24 years, which may be interpreted as a risk factor of retraumatisation.

A young person has no or little sexual experience to compare with the experience of the sexual assault (Pipher, 1997; Rasmussen, 2002), which means that she does not fully grasp what has happened. Lack of experience and understanding may imply a risk of serious after effects (Janoff-Bulman, 1992) as seen in the present study. It may intensify the internal splitting that the adolescent already feel (Erikson, 1992; Visholm, 2001).

The influence of alcohol/drugs
With regard to the influence of intake of alcohol/drugs on PTSD, the severity of PTSD was assessed as higher in the no-a/d group than in the a/d group. One explanation of this result may be that influence of a/d during a sexual assault, serves as a protection against intensity and frequency of trauma reactions, also in the long view. If the victim was not influenced by a/d during the assault she may have been more conscious of her sensuous and emotional symptoms during the assault and thus also in the aftermath of the trauma. This was confirmed in relation to physical complaints non-observed before the assault, which was found only in the no-a/d group.

The victims’ appraisal and experiences following the assault

Feelings of shame and guilt
Studies have found that victims of rape report a greater extent of feelings of shame and self-blame than victims of other traumas (Janoff-Bulman, 1992; van der Kolk & Mc Farlane, 1996; Newman, Riggs & Roth, 1997). Negative emotions, such as shame, have been found to impede recovery and predict PTSD (Brewin et al., 2000; Harvey et al., 2003).

Self-blame and fear of repetition was expected to be higher in victims influenced by alcohol/drugs during the assault compared to victims not influenced by alcohol or drugs, because alcohol and
drugs may have a distorting influence on the ways people perceive themselves and on the ways they are perceived by other people. The assumption was not confirmed. Generally the women of the present study experienced the violation as an act of humiliation, disrespect and desertion, provoking a picture of themselves as helpless victims filled with self-blame, shame, and feelings of being unworthy.

**Consequences following the trauma**
After a trauma additional stress may follow (Brewin et al, 2000; Ozer et al., 2003). This was reported by almost all of the women of the present study irrespective of the severity of PTSD. Consequences following trauma may be varied and for the victims of the present study the most stressful areas reported were contact with the police and the system of justice, pressure of work or exam, and negative reactions from other people.

**Sexual assault interferes with perception of oneself and others**
Since the harassment is caused by a person, the relationship not only to oneself, but also to other people is put to a test (Christianson, 1997; Jind, 1998). Risk factors of rape as reported by the victims themselves were being alone and influence by alcohol and/or drugs during the assault in the perpetrator and/or themselves. These are realistic considerations and may affect future behaviour in a positive way. On the other hand it may also imply a perception of oneself as vulnerable and helpless as a small dependent child, not relying on one’s own judgments. The present study seems to confirm this relation since the worst personal things mentioned by the victims were self-blame for not being able to prevent the assault, helplessness, lack of resistance, loss of control, and feelings of guilt and shame.

A more negative attitude to men and sex in general was reported by two thirds of the women, impeding new sexual relationships. One 20 years old, who was raped by her ex-boyfriend, said: “I have lost confidence in men; I reject them; I mistrust even the nicest guys. I have not had sex for over a year. “

Studies indicate that support after trauma has a great impact on recovery (Burgess & Holmstrom, 1974; Dyregrov, 1994; Frazier & Burnett, 1994; Christianson, 1997). Most of the participants experienced support from their closest network, but reactions from other people was reported as a mental strain: One 29 years old experienced that attitudes from people around her were intensified: “Some have become more critical to me, while others have become more positive.” Some victims related people’s reactions to their own mood: “It depends on how strong I feel. Do people think of me as the one, who was raped?” (one 27 years old). - “Maybe because I isolate myself; that I react
strongly, have my friends retreated. They do not call so often. Maybe they do not know how to
tackle me” (one 20 years old). Attitudes may also be connected to people’s opinion of the event: “I
experienced that people did not believe me. People had different opinions about it” (one 15 years
old). – “They keep me at distance. They said, that it was my own fault” (one 18 years old). - “I feel
hurt, affected, when somebody jokes about rape” (one 20 years old).

Somatisation tendency
Traumatised individuals with and without PTSD have demonstrated a pronounced tendency to
somatise (Ullman, 1995; Hilden, 2004), which was also found in the present study.
Physical complaints and change in eating habits were reported by more than half of the victims and
primarily by victims with middle or high scores of PDS. The complaints concerned physiological
areas and may be an expression of not wanting to deal with the body the victims might feel that the
perpetrator had deprived them of.
In addition to this, more than half of the participants reported having considered harming
themselves or had actually attempted to. The finding is concordant with results of other studies
indicating that PTSD is more strongly connected to suicide behaviour than other anxiety disorders
(Ballenger, Davidson, Lecrubier, Nutt, Foa, Kessler, McFarlane & Shalev, 2000; Langkafel & Senf,
2004).

Methodological considerations

The diagnostic instruments
When we talk about ‘disorder’ as in PTSD we talk about a pathological disturbance. A diagnosis
may pathologise transient stress reactions (Bryant, 2003) and may be perceived as stigmatising
(Marshall, Spitzer & Liebowitz, 1999). The categorical character of diagnostic classifications
implies an unfavourable understanding of normality and pathology as completely separated
conditions (McFarlane & Girolamo, 1996; Mortensen, 2001). Psychiatric systems of diagnosis may
be considered as ”neither sufficiently scientifically based, operationalised, reliable or valid, and
especially they suffer from a complete lack of theoretical foundation.” (Mortensen, 2001). Studies
on psychiatric diagnosis in both ICD-10 (WHO, 1994) and DSM-IV (American Psychiatric
Association, 2000) are based on the analysis of filmed interviews of real patients and causes of
mental disorders are based on hypotheses only (Slade & Andrews, 2002).
A diagnosis can be used to guide treatment selection, as well as to justify access to resources. The
risk by categorisation is, however, that treatment is offered only to individuals, who meet the
criteria of a diagnosis, and not to others, and such a differentiation would be too narrow to describe the width of the complex of a rape trauma. The intention of the present study was to attain a thorough understanding of rape as experienced by the victims to set up guidelines for psychological treatment. The CREI was designed and applied for that purpose, but its trustworthiness in providing reliable information to be generalised to other rape victims is scanty. Utility of the CREI needs to be verified on a larger sample of rape victims by other researchers than the present one.

Selection and information bias
There was a selection bias in the study since the participants differed from other victims of sexual assault enquiring at CVS. Only psychologically treated victims were included, and it was found that individuals who had other difficult conditions of life besides the sexual assault had not so frequently as others made use of the offer of psychological treatment. The researcher’s experience from her therapies with rape victims have, on the other hand, given her knowledge of the complex of problems in psychologically treated victims. In order to examine reactions to a rape experience in depth, which was the aim of the present study, it can be seen as an advantage that the researcher selected a study group, which she was already familiar with as a therapist.

The reliability of findings will decrease with each reduction of the study population and thus also the generalisability of results. There was a dropout from the initial study of ASD to the present follow-up interview implying some differences of the make-up of the present study sample compared to that of the ASD study.

The interview form was chosen for the study based on the view that an interview is more personal than a questionnaire and in that way the trust, which hopefully exists between the participants and the interviewer, might induce the respondent to be more truthful in her responses. The standardised interviews employed in the studies are thought to have the same advantages as questionnaires in relation to statistical analysis (Burns & Bush, 2000).

A serious bias of the design was that the follow-up interview was conducted at different time-intervals for the participants since the assault. Personal history and maturation since the trauma had influenced reactions and more so the longer time that had passed since the event. Due to the time and resources available it was not possible to avoid this bias.

Besides, the instruments used have not been standardised in a Danish sample, which weakens their reliability (Wilkinson, 2003). However, the ‘back translation’ method (American Psychological Association, 2002) employed should ensure a wording close enough to the English to make the scores comparable with scores of other studies.
The research took place at Copenhagen University Hospital, where the subjects had been treated following the assault and much information was self reported, which implies that the study may be encumbered with information bias. Being at the hospital again and going through the questions of the interview reminded some of the participants of the sexual assault. Some might have under-reported symptoms as a defence against flashbacks, others might have over-reported because the interview might have triggered aspects of the trauma. The main reason for not wanting to take part in the follow-up interview was a fear of having the assault reopened. This was also expressed by some of those who accepted participation: “At first I was not sure that I wanted to participate. The letter made some of the reactions emerge again. But thinking about it, I thought it was a good idea, if I could be of help to others” (one 17 years old). - “The invitation made the experiences gush forth again. I could not know how detailed I would be asked about the assault” (one 18 years old). Reports may also be coloured by the subjects’ considerations of how they would like to present themselves, and by their imaginations of what was expected from them in the situation. Alcohol/drugs were involved, which further may be a factor of not getting reliable information, and the time passed since the assault may also have affected recollections.

There is a risk of retraumatisation in follow-up studies of trauma, and ethics by carrying through research should be weighed in relation to the consequences for the people involved (Smith, 2003). Because the participants in the present study had received treatment free of charge the choice of participation may not have been completely autonomous and therefore psychological contact following the interviews was offered to all of those who were invited. The positive part of a follow-up interview, however, is that those who may have ended the psychological treatment too early are offered a second chance of entering psychotherapy. All victims who receive psychological treatment at CVS are offered renewed contact when needed after the treatment has ended, and quite a few make use of this opportunity.

SUMMARY AND CONCLUSION

The present study confirms results from other studies indicating that rape must be considered a serious traumatic experience in the short as well as in the long term. The prevalence and severity of posttraumatic symptoms had decreased after psychological treatment, but half of the subjects still suffered from severe posttraumatic symptoms. This raises considerations in relation to the therapy offered after an assault.
The study confirmed the assumption presented that age and intake of alcohol and/or drugs before the assault influenced reactions. Young age seemed to increase the prevalence and severity of trauma responses, while the influence of alcohol and drugs contrary to the expectation seemed to decrease the severity. The results of the study indicate that general responses to rape and attempted rape are of a physiological as well as of a psychological character: At a physiological level instinctive arousal occurs. Psychologically the individual realises her own vulnerability at a fundamental existential level, which results in development of coping strategies of avoidance to ensure survival.

Risk factors of rape as reported by the victims themselves were if they were alone and if they and/or the perpetrator had been under the influence of alcohol/drugs.

In tailoring to meet the needs of the individual after a sexual assault the results indicate that support and treatment services should consider the fact that all of the victim’s everyday life may be affected in the aftermath. Another fact to be considered is that the distress following a sexual assault may influence the individual at different levels of mental functioning. This implies that the victim may need help at a verbal, conscious level to redefine herself in relation to the trauma, to be able to create a meaning of the trauma and integrate it into a new mental scheme. But it may also be necessary to include therapeutic techniques to retrieve and treat symptoms imprinted by the trauma at a nonverbal, subconscious level.

The fact that more than half of the women accepted the offer of renewed psychological contact, when invited for the follow-up interview, raises considerations of offering a follow-up contact as a general offer to rape victims.

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Acute and Long-term Psychotherapy of Victims of Sexual Assault including Hypnotic Techniques

Annalise Rust

Abstract

This case study was carried out in order to elucidate therapeutic interventions in relation to victims of rape and to describe themes and issues presented during a therapeutic process. The study is based on the therapeutic records of six victims of rape. The victims were between 15-29 years old and had all met the criteria of the diagnosis of Acute Stress Disorder (ASD). To examine the victims’ condition in the long term, an assessment in relation to Posttraumatic Stress Disorder (PTSD) has been made. The study describes how hypnotic dissociation can be used to provide controlled access to subconscious reactions of trauma and thus constitute an important tool in the process of recovery. Results: Although ASD symptoms shined through in the victims’ complaints, other issues were prominent, too, especially concerning relational aspects. It is concluded that a diagnosis of ASD is not adequate for accommodating psychological treatment to the needs of rape victims. The most important approach in treatment is to tailor interventions to the complaints as and when the individual victim presents them, and at a pace she is ready for.

Key words: Rape, sexual assault, psychotherapy, ASD, PTSD, hypnosis

INTRODUCTION

The overall aim of the present study was to elucidate consequences of rape presented by victims in a psychotherapeutic process. By focusing on the process of recovery, it was thought that the understanding of the traumatic elements of a rape experience could be enhanced (Dahl, 2003). The paper presents the psychological treatment process of six victims of rape presenting at the Centre for Victims of Sexual Assault (CVS), Copenhagen, Denmark. Before the establishment of rape crisis centres in Denmark, it was found that only few rape victims reached out for psychological treatment (Hallmann, 1997). With the establishment of CVS in 2000, it was expected that a significant part of acute problems and long-lived consequences of a rape trauma could be prevented by an immediate intervention (Sundhedsstyrelsen, 1998).
Rape, defined as non-consensual vaginal, oral or anal penetration, is considered a trauma that may affect all areas of an individual’s life and all levels of functioning (Feeny, Zoellner, Fitzgibbons & Foa, 2000). Compared to other traumas, rape has been found to be the most devastating with an increased risk of post-trauma complications (Dahl, 1993; Foa, Hearst-Ikeda & Perry, 1995; Falsetti & Resnick, 1997). Since the trauma of rape is a psychological as well as a bodily invasion, inclusion of therapeutic interventions focusing on healing of psychophysiological reactions seems relevant. Psychophysiology deals with connections between psychological processes and bodily reactions, and is mostly non-verbal or subconscious (Rossi, 1993). Since rape is a ‘man-made’ trauma, cognitive processes, intrapsychic and interpersonal aspects may be affected and may need to be met therapeutically. Characteristic symptoms following exposure to an extreme traumatic stressor such as a rape are described in the diagnoses of Acute Stress Disorder (ASD) and Posttraumatic Stress Disorder (PTSD) (American Psychiatric Association, 2000). Assessment of ASD is a general procedure employed at the start of psychological treatment at CVS. It is used as a psychological tool for educating victims about the basis of symptoms, and about the relationship between the trauma and the physiological, psychological and physical state (Vanderlinden & Vandereycken, 1997; Nyamai & Njenga, 2000). The assessment is also used as an aid in adapting the process of treatment to the individual victim’s needs. Prospective studies have indicated that approximately 80% of people who meet the criteria for ASD subsequently develop chronic PTSD (American Psychiatric Association, 2000; Bryant & Harvey, 2002; March, 2003). By the development of ASD in 1994, the hope was that if risk factors of long-term consequences could be registered in the acute phase of a trauma, then the proper psychological treatment might diminish the risk (American Psychiatric Association, 2000).

The victims of the present study have been assessed as suffering from ASD (Rust, 2008a). After psychotherapeutic treatment at CVS, the victims have been interviewed and assessed in relation to PTSD (American Psychiatric Association, 2000; Rust, 2008b). Assessment of ASD was determined by a structured interview based on the Acute Stress Disorder Scale (ASDS) (Bryant & Harvey, 2002). ASDS consists of four clusters of symptoms concerning cognitive, emotional and psychophysical reactions (dissociation, invasion, avoidance and hyperarousal) occurring within one month following an extreme traumatic stressor (scores are from 1-5; total scores are from 19-95). Presence of PTSD was determined by a structured interview based on the Posttraumatic Diagnostic Scale (PDS) (Foa, Cashman, Jaycox & Perry, 1997). PDS consists of the three symptom clusters of the diagnosis of PTSD: reexperiencing, avoidance and arousal rated on a 4-point scale from 0-3.
Total scores are from 0-51 points (Dancu, Riggs, Hearst-Ikeda, Shoyer & Foa, 1996; American Psychiatric Association, 2000).

**Trauma and hypnosis**

It was an aim of the present study to elucidate how hypnosis could be utilised as a tool in the treatment of a rape experience. There seems to be a correspondence between trauma responses and responses during hypnosis. The basic concept of a traumatic experience is that the person is overwhelmed and trauma responses are seen as a reaction to this experience (Kingsbury, 1992; American Psychiatric Association, 2000). The altered state of mind caused by severe stress has been identified “as a form of spontaneous hypnosis which encodes state-bound problems of symptoms” (Rossi, 1993, p. 51) difficult to retrieve intentionally. Symptoms included in the ASD diagnosis resemble phenomena occurring during hypnosis, and research has also demonstrated a remarkable high hypnotisability shown by traumatised individuals (Classen, Koopman & Spiegel, 1993; Kirsch, 1996; van der Kolk, van der Hart & Marmar, 1996b). “Hypnosis can be understood as a state of aroused attentive focal concentration with a relative suspension of peripheral awareness and critical contextual evaluation” (Spiegel & Cardeña, 1990, p. 40). Likewise, a trauma may elicit a state of focused attention on aspects and reactions of survival value (Foa, Zinberg & Rothbaum, 1992) and suspension of awareness of other things.

There are similarities between the ASD symptoms of dissociation, invasion and hyperarousal and the hypnotic phenomena of dissociation, absorption and suggestibility (Spiegel & Cardeña, 1990).

**Dissociation**: Dissociation constitutes the main criterion of the diagnosis of ASD and can be understood as unconscious ways of distancing oneself psychologically from being overwhelmed. Dissociation is a neurobiological phenomenon (van der Kolk, 1986; Krystal, Bennett, BREmmer, Southwick & Charney, 1996), which in DSM-IV (American Psychiatric Association, 2000) is defined as a disturbance or alteration in the normally integrative functions of identity, memory, consciousness or perception of the environment. Dissociation may be regarded as a fragmentation in which experience is compartmentalised (Hilgard, 1977), and where events that would ordinarily be connected are divided from one another (Spiegel, 1988). In comparison, hypnosis is a structured means of eliciting dissociative phenomena where perceptions, memories and motor activities that would ordinarily be part of conscious awareness may occur out of consciousness (Hilgard, 1977;
Spiegel & Cardeña, 1990). When a person is dissociated, she is in an altered state of mind, which may result in an alteration of the normal mind-body encoding of experiences (van der Kolk, 1986; Rossi, 1993). Because uncontrolled dissociative states occur spontaneously during and after trauma, it makes sense to build on this capacity of trauma survivors employing the structured dissociation, which occurs during hypnosis (Hilgard, 1977; Spiegel, 1988; Classen et al., 1993; Bryant, Guthrie & Moulds, 2001; Cardeña, 2006). It is suggested that hypnotic dissociation can be used to provide controlled access to subconscious reactions to trauma (Brown & Fromm, 1986; Turner, van der Kolk & McFarlane, 1996; Chefetz, 2000; Bryant & Harvey, 2002; Robertson, Humphreys & Ray, 2004) that may otherwise be kept out of consciousness, e.g. intrusive memories, hyperarousal and fear reactions.

**Invasion:** A traumatic experience may be deeply imprinted in the organism and result in recurrent intrusions or re-experiences of the trauma in the aftermath, specified in the diagnosis of ASD as intruding images, thoughts and recurrent distress when reminded of the trauma (American Psychiatric Association, 2000). The traumatised individual becomes intensely absorbed in the memories of the trauma (Spiegel & Cardeña, 1990). Recollections of traumatic experiences will often happen unintentionally as uncontrollable intrusions, provoked by aspects reminding one of the original trauma, and where the person enters a similar state of mind as during the trauma (Rossi & Cheek, 1997). The absorption occurring in the hypnotic state can, on the other hand, be described as an intentional and controllable, highly focused attention on memories, images, thoughts, sensations and emotions.

**Hyperarousal:** The heightened sensitivity to environmental cues (symptoms of insomnia, irritability, and concentration deficits) and increased arousal (hypervigilance, elevated startle response, and autonomic arousal) in the diagnosis of ASD (American Psychiatric Association, 2000) are analogous to the component of suggestibility in a hypnotic experience, i.e. the heightened responsiveness occurring in the hypnotic state (Spiegel & Cardeña, 1990). Arousal is primarily a physiological response (Christianson, 1997), which mainly operates at a subconscious level, i.e. outside personal control (Janoff-Bulman, 1992).

**Avoidance** reactions may emerge involuntarily, but they mainly occur as voluntary mental and behavioural attempts to ensure survival and restore equilibrium (Horowitz, 1997; Barlow, 2004). The symptoms of avoidance in the ASD diagnosis may be seen as a coping strategy, a psychological
defence mechanism brought into play to suppress memories and reminders of the trauma (Hilgard, 1977).

It is suggested that the inclusion of hypnosis in psychotherapy of trauma may be an aid in “expanding the boundaries of the self, thereby diminishing the portion of the mental landscape experienced as alien” (Spiegel & Cardeña, 1990, p.41). Figure 1 is a model indicating how overwhelming stress is pushed out of consciousness, stored subconsciously, retrieved, re-experienced and integrated via the controlled hypnotic dissociation.

![Figure 1. States of Consciousness](image)

Brain scans have found that traumatic memories are stored in sensory-motor modalities (van der Kolk, McFarlane & Weisaeth, 1996), which means that they are not verbally accessible, but are recalled through somatic sensations and images. Hypnotic techniques make it possible to operate at a subconscious level, where the trauma, or parts of it, may be imprinted in what is termed as the ‘Situationally Accessible Memory’ (SAM) system (Brewin & Holmes, 2003). If the problem is solved at this level outside the individual’s conscious control, the assumption is that much of the unsuitable defence may be spontaneously dissolved and integration of the trauma can take place (Rossi & Cheek, 1997; Vanderlinden & Vandereycken, 1997).

**Hypnosis in psychological treatment**

Hypnosis has been found useful in treatment of psychophysiological stress reactions. Hypnosis may also be a useful tool in combination with cognitive-behavioural therapy (Classen et al., 1993; Kirsch, Montgomery & Sapirstein, 1995; Rothbaum & Foa, 1996; Schoenberger, 2000; Kilpatrick, 2004; Nishith, Nixon & Resick, 2005) and psychodynamic therapy (Rossi, 1980; Fass & Brown,
Cognition has to do with knowledge, insight and problem solving (Hougaard, 2004). How an individual mitigates the consequences of a rape trauma depends to a high degree upon the strategies she employs to cope with the trauma. Coping strategies are connected to mental schemes, which are relatively stable cognitive structures containing and organising assumptions, beliefs, and expectations about one self, other people and the surroundings (McCann & Perlman, 1990). The imaginative power of hypnosis may facilitate revision of mental schemes (Lazarus, 1966; Janoff-Bulman, 1992; Fine, 1996; Horowitz, 1997) to help the person to perceive her surroundings and interactions realistically and adaptively.

In psychodynamic therapy, hypnosis may be useful in adaptation to the trauma and in integration of self-psychological and object-relational aspects that may have been split by an experience of rape (Kohut, 1988; Herman, 1995; Michelson & Ray, 1996; Marmar, Weiss & Pynoss, 1996; Lindy, 1996; Resick, 2004). A psychodynamic way of putting the consequences of a rape into perspective is to look at how prior experiences from the individual’s life are activated by the trauma and may be part of the process of re-stabilisation now, i.e. an internal psychodynamic process. Another psychodynamic perspective is to look at the interpersonal dynamic process, first of all the impact of rape as an interpersonal trauma, but also on the impact of other people’s reactions to the rape victim post trauma.

No matter which theories and methods are recommended in psychotherapy of trauma, it is important that the interventions employed are able to meet the needs of the individual person at the functional level, and at the time and pace for which she is ready (Solomon, 1997).

In the present study, an approach of ‘utilisation’ was applied (Erickson & Rossi, 1976; Philips, 1995; Rossi & Cheek, 1997) in treatment. Utilisation is a phenomenological approach where the therapist bases her therapy on the form of appearance of the client, using the existing skills of the individual in the service of stabilisation of felt self-efficacy (Rossi, 1993; Philips & Frederick, 1995). Valuation of pre-existing traits and behaviours is believed to allow the person to feel understood and respected, and may thus function as an aid in the successful therapeutic process (Kingsbury, 1992).

The dialectic character of the trauma of rape implies that the healing process cannot be expected to run through progressive phases (Herman, 1995; Turnbull & McFarlane, 1996). Not all individuals may require all forms of intervention and it may be necessary to return to difficulties and problems, which have been treated earlier in the process. The psychological treatment offered to the
participants of the present study took place within a frame, built on principles considered important when dealing with traumatic experiences. The principles are based on ideas and assumptions that a traumatised individual needs to be re-stabilised and have the trauma integrated at different levels of functioning in order to adapt to the changes the trauma has caused. That is, a treatment process built less on promoting change, but more on stabilisation and integration of changes and disconnections caused by the trauma.

AIMS
The aims of the present case study were:

- To elucidate problems and themes as they were presented by victims of sexual assault at CVS during the psychotherapeutic process. In order to examine whether assessment of ASD could be an aid in accommodating psychological treatment, a comparison was made between the symptoms found in the ASD assessment and the problems and complaints presented by the victims during the therapeutic process.

- To describe the interventions employed in the therapy with a focus on hypnotic techniques as a tool in mitigating consequences of a rape experience.

METHODS
The present study was conducted as a process study (Hougaard, 2004), the intention of which was to explore a therapeutic process over time (Hougaard, 2004). To attain the aims of the study, the case study method was chosen because it was considered to be useful for developing in-depth knowledge about rape victims’ reactions and therapeutic needs (Launso & Rieper, 2000; Camic, Rhodes & Yardley, 2004).

Participants
Six victims of rape were selected to elucidate how consequences of a rape experience were represented as issues and aspects of the psychological treatment process, and how they were mitigated. Inclusion of six participants in the research was considered large enough in number to draw some conclusions from the results of the study. More than six cases could produce too much information for a thorough analysis (Kvale, 2004).
Criteria for admission to the study were that the participants had met the diagnostic criteria for ASD (American Psychiatric Association, 2000), and that they had returned later for a follow-up assessment of PTSD. The victims had participated in two other studies on acute and long-term consequences of sexual assault (Rust, 2008a; 2008b). The six cases were selected to represent varied demographic characteristics and variables related to the assault (Table 1), which were also seen in other rape victims presenting at CVS (Center for Voldtægtsofre, 2004). The participants were between 15-29 years of age at the time of the assault. Half of the victims reported an intake of more than five units of alcohol and/or drugs of medium or strong character (e.g. ecstasy, heroin, morphine) before the assault, and were thus considered to be under the influence of alcohol/drugs during the assault.

The participants had given their informed consent under subject anonymity by signing an agreement of participation and, to ensure anonymity, names and identifiable details have been altered.

Table 1. Demographic characteristics and variables related to the sexual assault

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>JANE</th>
<th>ALICE</th>
<th>IRENE</th>
<th>MARY</th>
<th>HANNAH</th>
<th>CONNIE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at the time of the rape (years)</td>
<td>15</td>
<td>17</td>
<td>29</td>
<td>20</td>
<td>22</td>
<td>27</td>
</tr>
<tr>
<td>Employed</td>
<td></td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Student</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td></td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Living alone</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td></td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Living with parents</td>
<td>with mother and stepfather physical illness</td>
<td>with mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical complaints prior to assault</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior trauma/strain</td>
<td>parents’ divorce</td>
<td>parents’ divorce</td>
<td></td>
<td></td>
<td>bullying</td>
<td>anorexia physical illness</td>
</tr>
<tr>
<td>Alcohol/drugs intake before the assault</td>
<td></td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Dissociative amnesia</td>
<td></td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Violence during assault</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical violence</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Threats of violence</td>
<td>yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship to perpetrator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friend or other acquaintance (&gt;24 hours)</td>
<td></td>
<td>yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occasional acquaintance (&lt; 24 hours)</td>
<td></td>
<td>yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stranger</td>
<td>yes</td>
<td></td>
<td>yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report to police</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
</tbody>
</table>

1 Reported an intake of more than five units of alcohol and/or drugs of medium or strong character (e.g. ecstasy, heroin, morphine) before the assault.

Jane

Jane was 15 years old when she was raped in a park where she was celebrating her last day at school before her exams started. At a time when she had withdrawn from her schoolmates, a young man, whom she had not seen before, came towards her. He dragged Jane behind some trees, threw
her on the ground, gripped her, and told her to keep quiet. He raped her vaginally, orally and anally. It was her sexual debut. The rape was reported to the police and they took Jane to the CVS for examination and treatment.

Jane was living with her mother, stepfather and little brother, but visited her biological father regularly. The relationship between her parents was conflict-ridden, which put considerable strain on Jane. Jane had a chronic physical illness, which was not shown and felt, but which made her worry about her future.

During a period of seven months, Jane received 11 psychotherapeutic sessions. She came back for two sessions with the psychologist one year and four months after the rape.

Alice
At the age of 17, Alice was raped by a young man at a party in a friend’s apartment where she and others, including the perpetrator, were staying overnight. The man had held on to her when she tried to resist, and had carried through vaginal intercourse. Alice judged that there was not much chance of the man being convicted for the rape, so she decided not to report the assault to the police. After the rape, Alice tried to forget the experience and not talk about it. More than a week passed before she told her mother, and a contact to CVS was established.

Alice was a high school student living with her mother and three brothers and sisters. Her parents had been divorced when she was a child, and for many years she had concealed from her mother that her father had violated her sexually.

During a period of about three months, Alice received eight psychotherapeutic sessions. After the follow-up interview 10 months post assault, Alice had another two sessions with the researcher.

Irene
When Irene was 29 years old, she was grabbed from behind by a man in the courtyard right outside her apartment. He held her and raped her vaginally. She was too afraid to shout and offer resistance. After the rape she took a bath, washed her clothes and went to bed. The next day she panicked and called a friend, who persuaded her to contact the police and seek treatment at CVS.

At the time of the assault, Irene was in the last year of her university studies and had a job in a restaurant to finance her studies. Irene found that her upbringing with both her parents and an elder sister had been safe and secure. However, she felt that her sister had outshined her in popularity with playmates.
During a period of 17 days, Irene received four psychotherapeutic sessions and then stopped the treatment when the researcher went on a one-month vacation. After the follow-up interview one year and seven months post-rape, Irene came back for another six therapy sessions.

**Mary**

Mary was 20 years old and had been sexually assaulted when she was abroad visiting her boyfriend. She had total amnesia about the assault, but her symptoms of hyperarousal and dissociation in the aftermath made her believe that she had been drugged and sexually harassed. No violence had been used since she had not been able to resist. The perpetrator was probably one of two men, who had accompanied her and another girl one evening when they went out on their own.

Mary lived alone, but had a close relationship with her mother and saw her father every now and then. The parents had divorced when Mary was a child, but she thought of her childhood as having been safe and secure. Mary was content with her job where she had mostly male colleagues. She liked the somewhat rough tone among them.

During a period of four months, Mary received six psychotherapeutic treatments. At the follow-up interview 10 months after the assault, Mary did not want therapeutic contact, but one year and two months post-assault she contacted the researcher again because she did not feel well and had three therapy sessions.

**Hannah**

Hannah, aged 22, had been out with friends and had had quite a large amount of alcohol. On her way home, she shared a cab with two young men who were going in the same direction. She did not remember anything more until the next morning when she woke up naked in her bed and found that her computer and other things were missing. Hannah believed that the men had given her drugs in a drink and had followed her when she left her friends. She reported the theft to the police, but her narrative made the police suspect a rape, and she was referred to CVS for examination and treatment. Three weeks later the police told her that the forensic examination had found remains of semen.

Hannah had grown up with her parents and a brother in a secure and loving family. She had recently left home and now lived in a shared apartment. Hannah had been bullied at school during childhood, and her parents had moved her to another school where she fitted in well with classmates. The bullying had resulted in a lack of self-confidence. Consequently, she cared a lot about her appearance and at times she had problems with eating.
During a period of two and a half months, Hannah received 10 individual psychotherapeutic treatments. After the follow-up interview two years and one month after the assault, Hannah had one session with the researcher.

Connie
Connie was 27 when a friend’s friend raped her after a private party. The man had suggested that, since they were going in the same direction, they might as well take a taxi together. She had fallen asleep in the taxi, and woke up when it stopped outside the man’s home. He persuaded her to sleep at his place where she fell asleep with her clothes on. No force had been used, but Connie woke up when the man was having intercourse with her. She pushed him off of her and fell asleep again until the next morning, when she left the apartment. Connie believed subsequently that she had been drugged. She chose not to report the incident to the police because as she said: “You cannot report something you do not remember.”

Connie was financing her studies by working in a kindergarten. Her immediate reaction after the assault was to “forget”, because she felt so humiliated and defeated that she could not bear thinking about it. She sought comfort with her family, but back in her own apartment she reacted strongly with no control of her feelings of aggression and sorrow. A friend helped her to seek treatment at CVS. She had cut herself and eating problems she had had 10 years earlier had returned.

Connie had grown up with a younger brother, a gentle mother and a very aggressive father, who once in a while had beaten her up. Since childhood, Connie had suffered from a back injury and recalled how embarrassing it was for her in adolescence when she had had to stand bare from the waist upwards in front of doctors and nurses.

During a period of four months, Connie received 14 psychotherapeutic sessions. She contacted the researcher again three months after the therapy had stopped, and had a further two therapy sessions with an interval of two months. After the follow-up interview one year and seven months after the rape, Connie came back for two more sessions with the researcher. In all, she had 18 therapy sessions.

Procedure

Data for the present case study was collected from psychological records based on themes and issues presented during therapy and registered by the researcher after therapy sessions. Summaries of the psychological records were made after the first month following the assault, again after three months and lastly at the renewed therapeutic contact with the researcher.
A content analysis of the six psychological records was conducted. This was made by categorising themes and elements of the therapeutic process. A technique of ‘meaning condensation’ (Charmaz, 2000; Launsø & Rieper, 2000; Giorgi & Giorgi, 2004; Kvale, 2004) was applied to reduce the content of the psychological records into shorter, more concise units (Kvale, 2004). The process of condensation employed was conducted by following A. P. Giorgi’s Systematic Text Condensation (STC) (Giorgi & Giorgi, 2004). The STC is developed to obtain knowledge about a subject’s experiences, meanings, etc. within a specific field (Giorgi & Giorgi, 2004). The following four steps were conducted in the process of condensation of the six therapy records: 1. Read for a sense of the whole to obtain an overall sense of the material to sort out themes and issues. 2. Establishing meaning units by rereading the descriptions and organising elements and issues as a first step in reducing the material. 3. Transformation of meaning units into the pre-planned categories selected from the researcher’s professional perspective in relation to the aim of the therapy (see Table 2). 4. Recontextualisation, which means to link the selected themes and issues into descriptions of the individual’s therapeutic process (pp.162-169).

The six participants in the present study had taken part in a follow-up interview to assess long-term consequences of the assault, including assessment of PTSD (Rust, 2008b). At the interview, participants were also asked if and how psychological treatment had been helpful. Responses to PTSD and answers concerning psychological treatment were included in the present study. The interviews were carried out by an assistant, a female student of psychology, who was unknown to the participants and who had no knowledge of the study goals.

RESULTS

One purpose of the present study was to elucidate problems and themes as they were presented by victims of sexual assault at CVS during psychological treatment. Another purpose was to examine whether the stress symptoms assessed by the ASD diagnosis corresponded to the problems and complaints that the victims actually presented in the therapeutic process. Categorisation of central common themes and issues of the psychological records are shown in Table 2. Some of the concepts contained under one heading may relate to those identified under others, i.e. they should not be seen as distinct categories. The table also includes information on scores of ASD and PTSD plus self-reports on outcome of psychological treatment.
Table 2. Categorisation of central themes and issues during the psychotherapeutic treatment process

<table>
<thead>
<tr>
<th>Central subjects and problems in therapy within the first month post-trauma (crisis intervention)</th>
<th>Number of psychological sessions</th>
<th>ASD severity (scores 19-91)</th>
<th>Highest mean ASD scores (1-5)</th>
<th>Central subjects and problems in therapy 1-3 months post-trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane (aged 15)</td>
<td>13</td>
<td>65 (after 3 days)</td>
<td>Dissociation (4.2)</td>
<td>- Revival of old problems: Revival of old problems: In relation to father</td>
</tr>
<tr>
<td>Alice (aged 17)</td>
<td>10</td>
<td>75 (after 12 days)</td>
<td>Avoidance (4.5)</td>
<td>- Strains in addition to the rape: Exam, police report, reactions from friends</td>
</tr>
<tr>
<td>Irene (aged 29)</td>
<td>10</td>
<td>69 (after 2 days)</td>
<td>Hyperarousal (4.2)</td>
<td>- Psychological reactions: Dissociative and hyperarousal symptoms; self mutilation</td>
</tr>
<tr>
<td>Mary (aged 20)*</td>
<td>9</td>
<td>76 (after 6 days)</td>
<td>Dissociation (4.6)</td>
<td>- Relational problems: Revival of old problems: In relation to father</td>
</tr>
<tr>
<td>Hannah (aged 22)*</td>
<td>11</td>
<td>80 (after 4 days)</td>
<td>Avoidance (4.5)</td>
<td>- Strains in addition to the rape: Exam, police report, reactions from friends</td>
</tr>
<tr>
<td>Connie (aged 27)*</td>
<td>18</td>
<td>69 (after 18 days)</td>
<td>Hyperarousal (4.7)</td>
<td>- Psychological reactions: Loss of control; hyperarousal; fear; anger; exhaustion, avoidance of feelings</td>
</tr>
</tbody>
</table>

Stopped treatment after 4 sessions

- Relational aspects: Boyfriend
- Psychophysiological reactions: Triggering of trauma; panic attacks
- Integration and re-creation: Self acceptance and tolerance; realistic perception of danger; adaptation to change; stabilisation and rehabilitation

- Relational aspects: Isolation and alienation; self blame
- Psychological reactions: Hyperarousal; flashbacks in dreams; triggering of old trauma; frequent infections
- Integration and re-creation: Looking to the future; adaptation to change

- Relational aspects: Feelings of powerlessness and helplessness; regression; inner conflict; ambivalence; alienation and isolation
- Psychological reactions: Avoidance; eating disorder; exhaustion; aggression; anxiety attack
- Integration and re-creation: Stabilisation on its way between intellectual control and emotional vulnerability; adaptation to change; hope for future

- Strains in addition to the rape: Work, sexual harassment
<table>
<thead>
<tr>
<th>Central subjects and problems at follow-up contact</th>
<th>Jane (aged 15)</th>
<th>Alice (aged 17)</th>
<th>Irene (aged 29)</th>
<th>Mary (aged 20)</th>
<th>Hannah (aged 22)</th>
<th>Connie (aged 27)</th>
</tr>
</thead>
<tbody>
<tr>
<td>After 1.8 years:</td>
<td>- Distance to rape: Well integrated</td>
<td>- Distance to rape: Changed identity</td>
<td>- Distance to rape: Changed identity</td>
<td>- Distance to rape: Well functioning</td>
<td>- Distance to rape: Well functioning</td>
<td>- Distance to rape: Well functioning</td>
</tr>
<tr>
<td>Relapse: Dissociation during strain</td>
<td>- Relapse by triggering</td>
<td>- Relapse by triggering</td>
<td>- Relapse by triggering</td>
<td>- Relapse: Anger and sorrow; avoidance</td>
<td>- Relapse: Anger and sorrow; avoidance</td>
<td>- Relapse: Anger and sorrow; avoidance</td>
</tr>
<tr>
<td>After 10 months:</td>
<td>After 1.7 years:</td>
<td>After 1.7 years:</td>
<td>After 1.7 years:</td>
<td>After 2.1 years:</td>
<td>After 2.1 years:</td>
<td>After 2.1 years:</td>
</tr>
<tr>
<td>- Psychophysiological reactions: Suppression of emotions;</td>
<td>- Relapse: Anger and sorrow; avoidance</td>
<td>- Relapse: Anger and sorrow; avoidance</td>
<td>- Relapse: Anger and sorrow; avoidance</td>
<td>- Distress: Need of intimacy</td>
<td>- Distress: Need of intimacy</td>
<td>- Distress: Need of intimacy</td>
</tr>
<tr>
<td>- Relational aspects: Isolation and alienation; ambivalence to treatment, fear of stigmatisation</td>
<td>- Relational aspects: Isolation and alienation; ambivalence to treatment, fear of stigmatisation</td>
<td>- Relational aspects: Isolation and alienation; ambivalence to treatment, fear of stigmatisation</td>
<td>- Relational aspects: Isolation and alienation; ambivalence to treatment, fear of stigmatisation</td>
<td>- Relational aspects: Isolation and alienation; ambivalence to treatment, fear of stigmatisation</td>
<td>- Relational aspects: Isolation and alienation; ambivalence to treatment, fear of stigmatisation</td>
<td>- Relational aspects: Isolation and alienation; ambivalence to treatment, fear of stigmatisation</td>
</tr>
<tr>
<td>Integration and re-creation: Adaptation to changed self, other people and daily living</td>
<td>- Integration and re-creation: Adaptation to changed self, other people and daily living</td>
<td>- Integration and re-creation: Adaptation to changed self, other people and daily living</td>
<td>- Integration and re-creation: Adaptation to changed self, other people and daily living</td>
<td>- Integration and re-creation: Adaptation to changed self, other people and daily living</td>
<td>- Integration and re-creation: Adaptation to changed self, other people and daily living</td>
<td>- Integration and re-creation: Adaptation to changed self, other people and daily living</td>
</tr>
<tr>
<td>After 10 months:</td>
<td>After 2.1 years:</td>
<td>After 2.1 years:</td>
<td>After 2.1 years:</td>
<td>After 1.7 years</td>
<td>After 1.7 years</td>
<td>After 1.7 years</td>
</tr>
<tr>
<td>After 10 months:</td>
<td>After 1.7 years:</td>
<td>After 1.7 years:</td>
<td>After 1.7 years:</td>
<td>After 2.1 years:</td>
<td>After 2.1 years:</td>
<td>After 2.1 years:</td>
</tr>
<tr>
<td>- Help to overcome trauma</td>
<td>- Help to overcome trauma</td>
<td>- Help to overcome trauma</td>
<td>- Help to overcome trauma</td>
<td>- Help to overcome trauma</td>
<td>- Help to overcome trauma</td>
<td>- Help to overcome trauma</td>
</tr>
<tr>
<td>- Integration of mind and body; normalisation</td>
<td>- Integration of mind and body; normalisation</td>
<td>- Integration of mind and body; normalisation</td>
<td>- Integration of mind and body; normalisation</td>
<td>- Integration of mind and body; normalisation</td>
<td>- Integration of mind and body; normalisation</td>
<td>- Integration of mind and body; normalisation</td>
</tr>
</tbody>
</table>

**Self-report on outcome of therapy**

- Return to reality
- Problems solved; also problems prior to assault
- Help to remove thoughts about the rape
- No personal loss by the meeting
- Recovered partly through the therapy; partly through the family
- Help to overcome trauma
- Integration of mind and body; normalisation

**PTSD severity at follow-up (scores 0-51)**

<table>
<thead>
<tr>
<th></th>
<th>Jane (aged 15)</th>
<th>Alice (aged 17)</th>
<th>Irene (aged 29)</th>
<th>Mary (aged 20)</th>
<th>Hannah (aged 22)</th>
<th>Connie (aged 27)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD scores (0-3)</td>
<td>Arousal 1.6</td>
<td>Arousal 2.4</td>
<td>Arousal 2.4</td>
<td>Arousal 2.4</td>
<td>Arousal 1.0</td>
<td>Arousal 1.6</td>
</tr>
<tr>
<td>Avoidance 0.7</td>
<td>Avoidance 1.9</td>
<td>Avoidance 2.4</td>
<td>Avoidance 2.4</td>
<td>Avoidance 1.6</td>
<td>Avoidance 0.9</td>
<td>Avoidance 1.6</td>
</tr>
</tbody>
</table>

*Reported an intake of more than five units of alcohol and/or drugs of medium or strong character (e.g. ecstasy, heroin, morphine) before the assault.
The most severe symptoms of ASD in the six participants were hyperarousal, avoidance and dissociation, corresponding to what was found in the other participants of the study on acute reactions (Rust, 2008a). As presented in Table 2, the symptoms found in the study on ASD assessment were shown through reports of psychophysiological problems as central issues of the psychological treatment during the first month following the assault. To Alice, however, relational problems seemed to be the most urgent to deal with in the acute aftermath of the rape. Irene ended treatment after four sessions, but when treatment was resumed more than one and a half years later, she reported several psychophysiological problems. In the other victims, psychophysiological reactions decreased over time, but were persisting as long-term relapses triggered by reminders of the trauma as indicated in Table 2.

Relational issues were central not only to Alice but to all the victims throughout the treatment. Other problematic issues were revival of problems and traumas prior to the assault and additional strains following the rape. Part of the strain was related to the rape such as police reporting, but strains in relation to work, study, and reactions from other people were central, too. The assumption that treatment of psychophysiological reactions would be the most conspicuous in the acute aftermath of rape was thus not fully confirmed, since other issues such as relational problems seemed to be just as important to deal with. To all participants, mind-body integration was a central issue in therapy, however.

Themes and issues concerning adaptation to the change the rape had caused were common for the victims, and were central throughout the treatment process being, as was assumed, most pronounced in the long term, i.e. after one month post-trauma.

The findings correspond to the results of other studies of sexual assault: Burgess and Holmstrom found in their Rape Trauma Syndrome (RTS) (Appendix D, p. 199) that disorganisation was central in the acute phase of the trauma, while the longer process after rape (i.e. three months post-trauma or later) was characterised by reorganisation (Burgess & Holmstrom, 1979). In a Norwegian study on sexual assault, Dahl (1993) found that trauma symptoms decreased in the course of time, but psychophysiological symptoms (arousal and somatic complaints) and phobic fear reactions (avoidance) seemed to persist. Other long-term reactions found in studies have been depression, self-blame, sense of guilt, and insecurity in human relationships (Dahl, 1993; Echstrøm, Welner, Helweg-Larsen & Theilgaard, 1993; Ehnhage-Johnsson, Skwarek, Seflin, Eriksson & Boström, 2003). In the present study, psychophysiological reactions reported as relapses were the most frequent reason for resumption of therapy, and PTSD symptoms of arousal
and avoidance were the symptoms most frequently reported. Other long-term reactions found in the studies mentioned were also seen in the present study, especially issues concerning interpersonal aspects (Table 2).

The results of the present study indicate that the ASD diagnosis may be a reliable tool in assessing acute psychophysiological stress in rape victims, and in that respect the diagnosis can be an aid in adjusting the acute psychological treatment. In relation to the complex reactions to rape, the ASD diagnosis is limited, however, especially because it does not encompass issues concerning self-concepts and interpersonal relations, which, as indicated, are very insistent with rape victims. For some victims, as shown in Alice, the most urgent problems to deal with in the immediate psychological treatment process may be relational rather than psychophysiological. Thus the most important approach in psychological treatment is to attune interventions to meet the individual, where she is, building on her resources and reports of what she needs to deal with for each therapeutic session.

**The course of therapies**

**Jane**
Initially in the therapeutic process, it was necessary to involve Jane’s parents to make sure Jane received the parental support she needed and was protected against the conflict that had existed since the parents’ divorce several years in advance. Jane felt that she had been a messenger between the parents, constantly taking care not to express positive attitudes towards the other parent. At the first meeting with the researcher three days post-rape, Jane felt split and out of control of her emotions, thoughts and behaviour. Distinct trauma responses appeared especially in ASD symptoms of dissociation (fragmented memory, depersonalisation and numbing) and hyperarousal (problems with sleeping, startle response and irritability).

Jane described her state as a sense of being simultaneously a ghost, a maniac, and a small child regressing to seeking basic trust in others to take care of her. She reported that it was difficult for her to sense herself after the rape. She had wanted to take her own life, holding a pillow over her face to ‘get away’, and she had stabbed herself in the hand in order to sense herself, and as a way of avoiding the psychological pain she felt.

By the end of the first month post-trauma, Jane felt so stabilised that it became important for her to find support in her peer group rather than her parents. This caused many quarrels with her mother, whom she felt was being overprotective.
Jane had been raped just before her examination period, and the strain from the exams triggered the stress responses from the rape. She reported having been at an exam, which she had passed, but she was shocked at experiencing a total blocking and emptiness inside her head. After this experience, she felt out of balance again for a period: restless, nervous, and alienated from herself. After three months, Jane had recreated a connection to her everyday life and accommodated to the changes inside her that the rape had caused; for example, a feeling of being an adult now. Her family had calmed down, too. Periodically, she felt very sad and sorry for having to leave the safety of her childhood. Her self-confidence was growing, and she aimed at belonging to the strongest peer group at school. It was very important for Jane to feel normal and to be acknowledged by peers. She had achieved a distance from the rape and had had a positive sexual experience with a young man. She felt changed after the rape and vulnerable, but she tried to hide it. When people looked at her, she felt that they could see the rape on her face.

Jane’s mother called the researcher 1.8 years post trauma, because Jane lately had felt very disillusioned. Jane was functioning well at home, but she had been accused of stealing and had lost her job. In a hypnotherapeutic imagination exercise, Jane went through the event and found out that the reason she had been on the point of stealing was that she had been missing her boyfriend, who had been on a vacation and she had wanted to console herself. By recalling the situation, she imagined how she could have acted differently to comfort herself just by calling him to hear his voice.

What had happened to Jane was that her feeling of loneliness presumably had evoked a dissociated dream state, out of conscious control. Through many years of childhood, Jane had suffered from her parents’ conflict, and the way she had tried to cope with her suffering had probably been through dissociation. Thus she had used this defence mechanism long before the rape and tended to fall back on it again when feeling pressured. She seemed quite well integrated at the follow-up contact, however, and the rape belonged to the past. She had a PTSD severity score of 13. Jane reported that the psychological treatment had helped her to go on and return to reality. Via the therapy, she felt that many problems had been solved, also including problems related to the time before the assault.

Alice
During the first few days following the assault, Alice reported that she had felt dissociated: the event had seemed unreal. When Alice came for treatment 12 days post rape, she exposed distinct
trauma reactions: *flashbacks* (related to bodily sensations, time and state of mind – awakening every night at the time when the rape took place), *nightmares, startle response, concentration problems*. Yet the most important part for her to deal with initially was the strain she felt in relation to her divorced parents and her mother’s boyfriend. She expressed disappointment at her mother’s lack of understanding of her feelings. Earlier parental conflicts and traumas in relation to her father were triggered by the rape and it became important for Alice to get a grip on the past to feel safe in her life in the present.

Within the first month post trauma, Alice’s psychophysiological distress had decreased and the assault was at a distance. Her relationship to other people was still in focus: she had broken up with her boyfriend since she did not trust him in relation to other girls. Alice made a lot of effort to relate to the changes in herself and to find a new balance in her close relationships. Three months and eight therapy sessions post rape, Alice felt stabilised in her everyday life and terminated therapy. Her relationship with her mother had become stronger and she was able to tolerate her mother’s boyfriend. Alice had found a new boyfriend with whom she felt very confident, also sexually.

After the follow-up interview 10 months post-rape, Alice came for therapy twice. She and her boyfriend had parted, and Alice was the one who ended the relationship. The rape trauma had been triggered by seeing a man who reminded her of the perpetrator and her fear had been intensified by the experiences of being sexually offended by a couple of young men at school. She had changed her appearance into a very feminine, bleached blonde look for fear that the perpetrator might recognise her. Alice had been rather boyish in her manners and looks identifying with her elder brothers. Shortly after the rape, she had changed her way of speaking, and now the change of identity seemed completed. The change could be understood more as a search towards feminine identity than as a way of hiding her identity and, in that respect, the change may be seen as a positive step in the process of finding a grown-up feminine identity.

Alice reported that the therapy had helped her to distance herself from the rape, so that she could still talk with the boys she used to talk to. She felt that she had ended the treatment too early the first time round, indicated also by a high severity score of PTSD (35) at the follow-up interview.

**Irene**

Irene had felt that her life had been in danger during the assault and blamed herself for ‘letting it happen.’ She was afraid that the shame she felt would become a part of her and, to prevent that, she tried to avoid everything reminding her of the trauma. The psychological treatment reminded
her of the assault and her attitude to therapy was ambivalent. When the therapy was interrupted after four sessions by the researcher’s vacation, Irene chose to end the treatment. One year and seven months after the rape, Irene called the researcher because she had symptoms indicating that the experience was not sufficiently treated, and at that time she exposed severe trauma reactions with both reexperiencing, avoidance and arousal. Irene was struggling very hard to find a new balance between her old ego and the changed parts of her that the trauma had caused. She had hesitated for a long time before contacting the researcher, again indicating her ambivalence towards accepting the impact of the trauma. One of Irene’s greatest fears had been that the rape would become a part of her, influencing her life. She still expended a lot of energy suppressing her emotions.

When the therapy ended Irene felt self-confident. She felt that she had succeeded in integrating mind, emotions and body so that she paid attention to all these parts of herself, but her new identity was still vulnerable in relation to other people and her score on PTSD was high (42).

At the follow-up interview, Irene reported that the benefit of the treatment was that there had been no personal loss on account of the meeting because the researcher had not known her before the rape.

**Mary**

Mary was ambivalent during the first month after the assault as to what degree the event should be allowed to fill in her life and, as a way of avoiding having to deal with what had happened, she had resumed her work already a few days after the assault. Mary felt alienated from her reactions and deceived by her boyfriend, who mistrusted her and blamed her for being unfaithful. Mary felt even more humiliated by this than by the assault, and sought rehabilitation by trying to convince her boyfriend that she had been drugged and thus unable to resist.

One month post-trauma, Mary’s boyfriend left her and, consequently, she felt very sorry, angry and humiliated, yet she interrupted the therapy. Mary telephoned and said that she had forgotten the appointments but that she felt reasonably well. Mary returned for treatment one month later because the assault and the loss of her boyfriend still occupied her thoughts and emotions.

Three months after the assault, Mary felt reasonably stabilised after six therapeutic sessions and was in a process of adapting to the changes that the assault had caused. She was more attentive to dangers than before and accepted her reactions of fear in these situations. She felt ready to let go of her boyfriend after a meeting with him, after which she felt that she had obtained satisfaction for
his unfair treatment. For her, this meeting was the last step she had to surmount in order to be rehabilitated and she could now go on without treatment.

At the follow-up interview 10 months post trauma, Mary was doing well and did not need psychological contact. She had a medium high PTSD score of 30. Fourteen months post assault, Mary returned for therapy feeling that all her trauma symptoms had recurred. She was very sad and also angry. She was dissatisfied with herself and had difficulties at work because she was being very quick-tempered towards her colleagues. Lately, she had often reported sick and her boss had discussed it with her.

It was comfortable for Mary to return to the researcher who knew her story, but she had hesitated for a long time because she thought that her problems might not be serious enough to bother about. Mary felt that she was almost back where she started after the assault, and did not know what to do about it. She used to be so content with her work and her colleagues, but now it was hard for her to be there mostly because she could not control her reactions and, as a defence, isolated from her colleagues. When working through in hypnosis an incident she had had with her colleagues where she felt that they did not respect her, she realised that the incident was connected to her situation immediately after the assault when she had felt deceived and disrespected by her boyfriend. The experience of disrespect now had triggered her feelings from then.

After this session, Mary felt at peace with herself. She was busy at work again and felt happy, something which her boss had noticed and commented on. It was as if things had fallen into place, and this was a great relief for her. Mary felt recovered. The assault belonged to the past, and she was satisfied with things around her. She had hopes for the future both in relation to work and personal intimacy.

Mary felt that the psychological treatment had been a great help: she had needed to talk it over with someone who did not know her and who had experience in therapy with rape victims. She felt that the reason for her recovery was partly due to the therapy, partly due to her family’s support.

Hannah

Hannah’s assumptions about the world and herself had been severely shattered by the event, and she felt that she was a complete failure. This confirmed earlier experiences of not being able to live up to her own and other people’s expectations. Her normal feeling of being a good judge of other people had failed her, and she had completely lost confidence in herself. The two men who had raped her had been smiling, charming, well-dressed and quite “normal” – they had not at all looked like what Hannah had imagined criminals would look. Hannah blamed herself for her
foolish behaviour and was afraid that her friends and other people might reject her. She felt very ashamed and guilty.

Hannah experienced severe trauma symptoms of fear and psychophysical strain, which disturbed her sleep during the first month post-trauma. Her eating was likewise disturbed, which had also been the case when she was younger. She checked her weight several times a day but realised that struggling with her weight was a way of distancing herself from the problem. At the same time, it gave her the feeling that she was in control with things. She also suffered from feelings of loss and sorrow, and wished that she could have spared her parents from the misery caused by the trauma. Step by step, she became able to re-conquer her world. Her priority in the immediate aftermath of the event was to find trust in other people, first of all her family. When this was secured, she turned to the broader world to find security in her everyday life. The rape event revived memories of being excluded from her peer group as a child, and feelings from that time of not being good enough and pretty enough broke out again. Hannah was still exhausted after the first month post-trauma, and the trauma kept on popping up in her dreams, but she had confidence in her own resources to recover.

The next step for Hannah in the process of recovery was to adapt to the change the trauma had caused. Hannah’s shattered assumptions about the world (Janoff-Bulman, 1992) raised existential questions in her concerning what to prioritise: the safety and security back home protected by her parents or taking on the responsibility of trying to create a new independent grown-up life. Hannah knew that her decision would have a crucial impact on her future life and that the responsibility of what to decide was hers alone. This exhausted Hannah, and she just wanted to sleep all day doing nothing.

It took Hannah two and a half months to undergo the process of adapting to the changes the assault had caused her and to reach the decision to remain in her apartment. The experience had changed her attitude to other people: while the experience had affirmed her of the importance and the strength of her relationship to her closest family, it had made her more sceptical towards other people. After the rape, she felt much older than before and more responsible for her own life. Although she was still not satisfied with her looks, when the therapy ended after 10 sessions she had confidence in her own abilities and was hopeful about the future.

At the follow-up interview 2.1 years after the assault, Hannah reported that the psychological treatment had helped her to overcome her trauma. It had been a relief for her to talk to someone who understood how she felt, and who could open up to what was painful – and close it again. She
had found it of great importance that therapy had been available as long as she had needed it, without any time pressure.

Hannah came once more for therapy after the follow-up interview. She was doing quite well, and her scores of PTSD severity were low (12). Hannah longed very much to have a boyfriend, but was about to give up hope, because she became very shy in the company of men she felt attracted to.

**Connie**

Connie was very upset when she came for therapy. She had tried to calm herself with the assistance of alcohol and smoking. In order to relieve the feelings of aggression she felt towards the perpetrator, she had cut herself in her thigh and arm.

Since Connie was 16-17 years old, she had been suffering from anorexia and bulimia. She had been in psychiatric treatment and without symptoms for several years. After the assault, her eating disorder had returned and she was afraid of having to go through extensive treatment once again. Fortunately, Connie was aware that the eating disorder was a way of maintaining emotional control by displacing emotions with vomiting and nausea. Connie realised that due to the back injury she had had since childhood, she had developed a poor body-consciousness and had survived mainly by relying on her intellectual abilities. She wanted to find a better balance between mind and body.

During the first three months post-rape, Connie fought with ambivalence in realising the great impact the rape had had on her. She felt that the perpetrator was a person so inferior to her that it was extremely humiliating for her to accept that he could have affected her so deeply. Connie had previously sought recognition from other people prior to the assault by means of her good intellectual abilities and her achievements. The assault had reminded Connie that she was a vulnerable woman, and that her usual way of handling things by intellectual defence had not worked out. It frightened her not being able to control her emotions and bodily reactions.

Fortunately, she had mainly felt that the people important to her had supported her and still respected her. She became able to prevent her eating disorder running out of control, and she was on her way to finding a new balance between mind, body and emotions, acknowledging the importance of all three parts for her well-being. An episode of sexual harassment by a colleague at work had made her consider retreating to her old survival kit, the eating disorder, but she realised that she did not need that kind of ‘help’ any more to suppress her emotions.
At the follow-up interview 1.7 years after the assault, Connie felt that she was functioning better than before the assault, now allowing herself to be vulnerable and admitting that she needed a close relationship to a partner. She had a medium high score of PTSD (24).

Some time after the follow-up interview, Connie asked for an appointment with the researcher. Connie hardly thought of the assault any more, but lately she had felt more ill-tempered and she feared her own reactions. She felt that something inside her was wrong. She had had a relationship with a man for several months and considered moving in with him, but she had had some problems relating to him sexually. Once the man had asked her to touch his penis, and immediately she had frozen. When he had calmed her, she burst into tears. It was still a bit strange for Connie to have feminine reactions, such as crying or bursting into tears. She felt silly and vulnerable, but she was ‘practising her femininity’.

In relation to the psychological treatment, she reported that she had really needed to talk to someone to be informed that her reactions were normal. It had helped her to feel less “psychotic” having her hot temper linked to the reactions towards the assault. It had been very important for Connie that the therapeutic contact had been available to the extent and at the times when she had been in need of it.

**Therapeutic interventions**

Hypnosis was used as a tool with the six participants in order to facilitate stabilisation of psychophysiological, cognitive-behavioural and psychodynamic imbalances.

When trauma overwhelms the psyche, a fragmentation of consciousness occurs (Straker, Watson & Robinson, 2002). These fragments may be experienced as “personified beings” (Straker et al., 2002), not integrated with one another. One of the functions of hypnotic dissociation may be to assist the victim in connecting the ‘part of her, struck by the assault’ with the ‘resilient part of her’ making her able to confront the traumatic event and at the same time use the resilient part to decrease conditioned physiological responses triggered by the trauma (Kingsbury, 1988). In the example of Mary above, the hypnotic state made her aware that the part of her connected to the assault in the past had been triggered by the present situation with her colleagues, which helped her regain control and resolve the pain.
Hypnosis in stabilisation of psychophysiological stress reactions
Severe psychophysiological stress responses were seen in all six participants, markedly in the acute aftermath. All participants felt split personally and out of control of emotions, thoughts and behaviour.

By suggesting progressive relaxation of the body, a hypnotic induction was introduced to all participants to help the victim draw attention to her inner states, primarily bodily states, as the first steps towards regaining control and recapturing her body. Since breathing affects muscle tensions and thus also emotional and cognitive functions (Rossi & Cheek, 1997), the task of deepening the breathing may in itself be instrumental (Thornquist & Bunkan, 1986) in making mind and body communicate again (Rossi, 1993; Michelson & Ray, 1996). After the trauma, Hannah was extremely exhausted and realised that things needed to settle down. However, in spite of sleeping 10-12 hours every night, she did not feel rested. Through an exercise in relaxation, Hannah sensed peace in her body, and also that she very much needed this peaceful feeling. She sensed strength in her abdomen, but also tension. The sensations gave her positive feelings about herself and hope for the future.

Relaxation helped Mary become aware of her mind-body splitting and thus reconnect with her body. She sensed an inner strength, which gave her self-confidence and assured her that she was physically able to defend herself under any circumstances, which she also could have done in the assault situation had she not been drugged.

The splitting between body, emotions and mind were common to Irene and Connie, and expressed as ‘a strong mind blaming a weak body’. They both had many psychophysiological complaints: muscular tensions, sleeping problems and physical exhaustion. Irene complained of a constant headache. Through an exercise focusing on her body, Irene sensed a lump in her abdomen; she also sensed that her breath was hectic and that she was unable to relax her eyes and forehead. Becoming aware of breathing and bodily sensations gave Irene an idea of how she was able to influence her well-being and regain a sense of control. When Connie was focusing on her body, she sensed strength in her breast like armour, and imagined how she could use this strength as a protection in situations with many people present. Afterwards, Connie said that she had become aware that she had not owned her body for many years, and she could see the meaning of ‘reconquering’ it as a way of regaining personal safety and control.
Hypnosis in treatment of cognitive-behavioural imbalances

Before starting to examine and treat the trauma, it is important to help the victim find a stable grounding in her self (van der Kolk, McFarlane & van der Hart, 1996a), thus increasing her ego-strength, self-confidence and ego-control. To ‘work through the trauma’ without establishing safety and control may overwhelm the victim and result in retraumatisation. In the inner focused hypnotic state, imaginative techniques were utilised to empower the participants to tolerate the arousal of confrontation with the trauma anew. Imaginary ‘safe anchors’ (Philips & Frederick, 1995; Frederick, 1996; Frederick & McNeal, 1999; Rotschild, 2000) were used to suggest that the victim imagined a situation or place where she felt or had felt completely safe and secure. Helping the victims to be aware of and feel their ‘inner strength’ of survival (as mentioned in Connie above) was another important step in regaining control and mitigating consequences of the trauma.

When Alice focused on her body, she sensed great tenseness in her arms and legs; she sensed it as an impulse to push away the perpetrator and imagined how she did it and escaped. The reframing of the trauma may have helped Alice calm herself later at an exam where a young male examiner reminded her of the perpetrator. Alice had managed not to panic and had passed the exam with a satisfactory result.

During a hypnotic session, Irene sensed her inner strength in her shoulders and breast as a pride, but she felt that its ‘wings were clipped,’ since she had not been able to use this strength to escape the rape. By means of the hypnotic technique ‘affect bridging’ (Watkins & Watkins, 1992), feelings of insufficiency in her childhood in comparison with her elder sister emerged. Irene had at that time felt tempted to react physically, but had never done so because her sister always reacted physically when they were children. Instead Irene had developed strong verbal and intellectual abilities and resources, and had used these as coping strategies in emotional control. By use of the controlled therapeutic dissociation, Irene was able to imagine separating herself into two ‘ego-parts’ (Watkins & Watkins, 1996), one of which was experiencing, and another one, which was helping. Doing this enabled Irene to reconcile herself to the spiteful feelings of her ‘child-part’ towards her sister with whom she now had a very close and affectionate relationship.

Aspects of the trauma may reactivate prior histories of mental loads (van der Kolk, 1996; van der Kolk & McFarlane, 1996; Resick, 2004), as shown in Irene. This also showed up in other participants: for Jane and Alice in relation to the problems they had experienced after their parents’ divorce. In the case of Alice, for example, where old feelings emerged of being let down by her mother, who had not protected her against her father’s intimidations. For Hannah, the trauma
evoked feelings of unworthiness and disturbed eating patterns as when she was younger, where this was provoked by bullying from peers.

Connie’s former eating disorder and self-mutilating behaviour re-emerged for a while and frightened her, making her think that she had to go through long-lasting treatment as before. The coping mechanisms the victim had used pre-trauma may not be experienced as effective during and after trauma (Resick, 2004). The fact that Connie’s rational way of coping turned out to be insufficient in relation to the assault made it necessary for her to find new ways of coping.

**Hypnosis in treatment of psychodynamic imbalances**

To dissolve post-traumatic stress responses, re-exposure to the trauma may be necessary (Foa, Keane & Friedman, 2000; Wessa & Flor, 2002). The reason why exposure therapy is thought to be effective in reducing trauma symptoms is that the activated fear response is combined with new information (Rothbaum & Foa, 1996). This can be seen in the example of Mary above, who was helped by separating the ‘now’ from the ‘then.’ Through the experience of being able to face and master anxiety, a new memory can be formed, and cognition can be completed (Lang, 1979; Horowitz, 1998). The self-confidence and competence experienced through hypnotic imagination can be transferred into courage to face the external reality (Shorr, 1974; Torem & Gainer, 1995). ‘Substitution’ (Janet, 1889) is one possible hypnotic technique in which one imagines a more positive process of the trauma than in reality as mentioned in Alice above, where she imagined that she escaped from the perpetrator.

Another example of substitution was when, in the hypnotic state, it was suggested to Irene that she imagined seeing her rape on video. Going through the event a couple of times enabled her to reframe it, experiencing how she resisted the perpetrator and rendered him harmless.

Therapy must render as much responsibility to the client as she can handle (Vanderlinden & Vandereycken, 1997); thus the integration of the trauma must take place at a pace the person can tolerate (Morton & Frederick, 1994). To prevent retraumatisation, panic must be avoided, but the therapist should not be so cautious that the client is not challenged. Irene had been struggling to find a balance between her old ego and the changes the trauma had caused. By challenging her beliefs and by being emphatically attuned to the affects that triggered the trauma, Irene was slowly encouraged to allow some vulnerability in regard to both herself and others.

Strains in addition to the rape may require a return to treatment of problems from earlier phases of the healing process: for example, the strain Jane had felt due to an examination had triggered trauma-related cues of arousal and dissociation, and the reactions she had experienced in the acute
aftermath of the rape had returned. Once again she felt quite out of control. Thus the therapeutic work again had to focus on stabilisation of reactions using hypnotic techniques of imagination, where Jane visualised how she entered her head, brought order to the chaos in there and made a priority of what to deal with first: a lost boyfriend who had deceived her. This seemed an important step for Jane to regain confidence in men and also to strengthen her self-esteem.

Avoidance and ambivalence

Avoidant behaviour is frequently found in victims of sexual assault (Shipherd & Beck, 1999), as a tendency to guard themselves against confrontations with reminders of their trauma, including psychotherapeutic interventions (Bencke, Welner, Bramsen & Helweg-Larsen, 1988; van der Kolk & McFarlane, 1996; Bryant & Harvey, 2002). Avoidance was also seen in the participants of the present study. Irene and Connie felt that what had happened was so painful that they initially concentrated all of their attention on disconnecting from the experience and from their emotional and physical selves. They both considered it a sign of feminine weakness to express emotions since this part was felt as not controllable. They both tried to hold on to the part of themselves that the rape had not affected: the intellectual mind. Irene blamed herself for the rape and she felt that something was utterly wrong with her since the rape could happen. She said that one of her greatest fears was that the rape would influence her life, and she did her utmost to avoid letting the rape be a part of her. Her attitude to psychological treatment was ambivalent, so when a necessary break in the contact occurred, Irene terminated treatment. One year and seven months later, Irene contacted the researcher again with severe stress symptoms indicating that the trauma had not been sufficiently treated.

Connie’s immediate reaction after the assault was to ‘forget’, because she felt so humiliated and defeated that she could not bear thinking about the assault.

After a sexual assault, the victim may feel out of control and helpless like a child (Rossi & Cheek, 1997; Nijenhuis, Vanderlinden & Spinhoven, 1998; Stern, 1998), and in need of contact to people she is attached to. The four participants who did not live with their parents all went back to them and stayed with them temporarily after the assault.

Victims of sexual assault, however, often hesitate to ask for the help they need from various people because they feel guilty, both for what has happened to them and for the sorrow and worry the assault loads onto their surroundings (Younger, 1995; van der Kolk & McFarlane, 1996). Irene’s immediate impulse was not to tell her parents about the rape, but she needed their support.
and decided to follow the researcher’s suggestion and inform them. It was the sexual part of the rape she felt was very embarrassing, and when her mother wanted to know more details, Irene refused.

It was difficult for Hannah to see her parents devastated when she told them about the assault, and she wanted to protect them. She realised, however, that it would be wrong not to tell them how she felt since she needed her parents’ support very much.

Mary went to work immediately after the assault, not telling her workplace about the experience and using her job ability to convince herself that she was well functioning. She needed support from other people, but hesitated to ask for it because she did not want to strain family and friends any further.

Recovery and follow-up contact

On average it took three months for the six victims to feel recovered to the extent that they were ready to terminate psychological treatment. The common denominators reported by the victims for feeling recovered were all connected to feelings of stabilisation in mind and body and externally in relation to the changes the trauma had brought about.

Although all participants regarded change as positive and necessary after the assault, the change was also experienced as a psychological loss: the loss of an innocent childhood as expressed by Jane and Hannah, the loss of friendships and relations for some, and the loss of a safe and secure world for all of them. A victim of sexual assault may have to go through a process akin to mourning (Burt & Katz, 1987), taking leave of life as it was prior to the assault.

At the follow-up interview, two of the participants, Jane and Hannah, had so few symptoms that they could not be considered as traumatised (see Table 2, p.159). Connie and Mary had a medium high score of PTSD severity, while Alice and Irene were assessed as having a high degree of PTSD symptoms. Alice and Irene both felt that they had ended treatment too early, and this may be connected to the persistency of their posttraumatic stress symptoms.

In five of the six cases, there seemed to be a need for having the possibility of psychological follow-up after the end of treatment. The complaints at follow-up contact seemed to be related to situations that had triggered imprinted reactions to the trauma: Jane had relapsed into dissociation through her feelings of loneliness; in Alice, a sexual offence and seeing someone resembling the perpetrator had caused a relapse into traumatic responses. Feelings of deception and disrespect from colleagues made Mary relapse into reactions she had had in the acute aftermath of the assault.
Positive experiences may also trigger trauma responses, as with Connie when she considered moving in with her boyfriend.

Thus, even if the manifest symptoms of the trauma seem to be remitted and the individual victim feels recovered, a longer-lasting vulnerability to experiences provoking affect and arousal may remain in the individual (Hunter, 1995; Casement, 2005). Recovery from a rape experience must therefore be considered “a deeply personal, highly individualised, and multidimensional phenomenon” (Smith & Kelly, 2001, p.339), which raises considerations not only in relation to the interventions employed, but also to the length of psychological contact offered.

The study elucidated how hypnotic techniques were employed as an aid in recovery from a rape experience. Hypnotic techniques were suggested because they facilitate access to nonverbal, subconscious symptoms, reactions, and resources, e.g. bodily reactions, as mentioned. Other techniques might be just as useful, but what seems important in accommodating a therapeutic process in relation to rape victims is that the interventions employed are flexible and able to mitigate the consequences of the assault at conscious as well as subconscious levels of functioning.

SELECTION AND INFORMATION BIAS

The aim of the present case study was to examine the process of recovery viewed from the perspective of the individual victim. Although a process study like the current case study may complicate comparisons with other studies (Mertens, 2003; Hougaard, 2004), it may be suitable for capturing the complexity of a process of recovery and thus be a way of collecting important information on rape victims’ reactions of relevance for adjustment of the therapeutic process. The results of the present study should be considered with caution, however. Firstly, the psychological records were secondary data not kept specifically for collection of data for the present study. The records were incomplete and selectively recorded depending on themes and issues appearing in the individual therapy processes. Secondly, the psychological records employed as data in the study were the researcher’s own records. She alone conducted the examination and condensation of the data and the interpretation of the results. Since the main material for the study was therapy, the material might be more diffuse and fragmented than answers to an interview and this can be seen as a limitation, too. Furthermore, the therapist has much greater influence on the direction and content of a therapy session than on an interview and, above all, she can solely decide what to attach importance to in
the written report (Kazdin, 2003). There is a possibility that important aspects were not registered by the researcher and perhaps not even mentioned by the participants, who may have been inclined to adjust to ‘the therapeutic style.’ Some of the bias has been diminished, however, by having a neutral interviewer carry out the follow-up interviews (Rust, 2008b).

The sample size is small as in most qualitative research and thus not representative of female assault victims, not even of the women presenting at CVS. The reliability of the results and their generalisational value should thus be taken with caution, and the results require confirmation from further studies. However, the advantage of qualitative studies is that these methods are useful in obtaining deep insight into psychotherapeutic processes.

SUMMARY AND CONCLUSION

The objective of the present study was to put into perspective the process of therapy in order to accommodate the treatment to meet the varied ways in which individuals may react to a sexual assault. The study has focused on themes, trauma responses and therapeutic interventions presented through six cases of victims of rape. The central themes and responses reported by the six victims indicate that sexual assault may affect the individual’s function in a variety of ways and at different levels of functioning thus indicating the importance of accommodating psychological treatment to the individual’s needs and readiness.

The traumatic dissociation of affective, cognitive and somatic aspects reported by the participants was viewed as paralleling the structured dissociation in hypnosis. It was described how hypnosis as a technique operating at nonverbal, subconscious levels might be useful for creating possibilities of re-association of mind and body and in adaptation to the cognitive, intrapsychic and interpersonal consequences of the trauma.

It took on average three months for the six victims to feel stabilised in relation to the changes the trauma had brought about and to be ready to terminate psychological treatment. However, the follow-up contact indicated that, even if the victim seemed recovered, longer-lasting psychophysiological vulnerability remained and triggered the trauma. This vulnerability raises considerations in relation to limitations of the interventions employed, but also in relation to the availability and length of the psychological therapy offered.

It appears from the study that it is important for a successful therapy after sexual assault

- That the victim can take the time that is needed for her to recover at her own pace and
That she is offered the possibility of resuming treatment if needed.

The present study indicates that victims of sexual assault hesitate to take the initiative to seek the needed professional help. As a preventive step in relation to treatment of recurrent symptoms, it might be considered that the therapist be the one who invited victims for a follow-up contact some time after the end of treatment.

Since research of rape trauma therapy is a relatively new area in Denmark, the present study should be seen as a preliminary step in surveying themes and aspects appearing in psychological treatment.

The selection of focus of the present study implied that important themes and areas concerning rape victims were not included, or only superficially dealt with, for example the sexual aspects of the assault. This and other issues have to be considered in future studies to obtain a more detailed knowledge of how the psychological impact of sexual assault can be diminished.

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REFLECTIONS ON THE RESEARCH PRESENTED

The objective of the studies of this research was 1) to assess acute and long-term reactions to rape or attempted rape among women enquiring at the Centre for Sexual Assault, Copenhagen (CVS) and 2) to describe the psychological treatment offered at CVS. Variables connected to the assault, to the victim herself and to her everyday life were examined in relation to their impact on post-assault reactions and on the process of recovery.

The impact of rape and attempted rape must be considered as multifaceted. Although there was similarity in the participants’ responses to the sexual assault, rape victims cannot be universally classified and treated homogenously. As shown in the studies sexual assault produces various responses and reactions and thus also demands various and flexible psychotherapeutic interventions in the aftermath.

The results of the studies indicate that many factors influence these responses and reactions. The factors present in each victim’s rape experience may enhance or hinder her recovery opportunities and processes. The rape victim’s experience can be divided into processes surrounding the actual assault, the responses the victim has after the rape, and the psychological and social impact of the rape and the process of recovery.

Of the factors that were identified and discussed as influencing the responses of the rape victim after the assault, reactions from surroundings seem to have a substantial impact. The studies elucidated how the victim was at risk of re-victimisation by the systems she enters into after the rape, such as the legal, medical and social systems. These circumstances are unique to rape victims and not to victims of other crime.

**Methodological considerations and limitations**

A sample validation was made by comparing the study sample’s demographic and assault profile with the profile of all enquiries at CVS. This comparison indicated that it would be acceptable to consider the sample included in the studies as representative in many respects of the total population of enquiries at CVS.

Differences were found on the profiles compared between the study group and the whole group of victims referred to psychological treatment at CVS, for example according to age. The fact that the study group was a little younger on average than the whole group may have influenced results. Yet it was considered acceptable to draw the conclusion that the results to some extent were applicable to other women who have attended psychological treatment at CVS.
The sample accuracy (Burns & Bush, 2000) and thus also the representativeness of the findings would have been improved considerable if the sample had been larger and if the studies also had included women, who had not attended psychological treatment.

As in the present research the conditions of clinical research often are that the person carrying out the research is identical with the person treating the participants included in research. This dual role limits the validity of the results, since there is a possibility that important aspects are not registered by the researcher and perhaps not even mentioned by the participants. On the other hand the acquaintanceship between therapist and client may create a possibility of getting more in-depth information.

Much information was self reported, which implies that the research may be encumbered with information bias. Alcohol and/or drugs were involved, which may be a further bias in not getting reliable information. Furthermore, the instruments used have not been standardised in a Danish sample, which weaken their reliability (Wilkinson, 2003).

A further disadvantage of the study was that the psychological records included were not systematised according to the studies in question.

The selection of focus of the present research implied that important themes and areas concerning rape victims were not included or only superficially dealt with, for example the sexual aspects of the assault. Future research is needed to attain a more detailed knowledge of how the psychological impact of sexual assault can be diminished.

**Perspectives and implications for future research and practice**

**Implications for future research**

The results of the research indicate prophylactic steps in relation to mitigate consequences of rape and attempted rape. It seems important to examine how to ensure treatment for those who do not accept the offer of psychological treatment at CVS, since some of these women might be the ones most in need of support and treatment. The present studies indicate that the victims not accepting the offer of psychological treatment are individuals with less personal resources than those who accept the offer. Prior or present strains besides the assault may intensify reactions in the aftermath exhausting the victim to an extent that entering treatment seems overwhelmingly. In relation to these victims a more active reach out may be considered.

Adolescent victims of sexual assault were found to exhibit more severe reactions in general than older victims. This finding may imply that young victims of sexual assault have special needs for treatment. To comply with this the individual treatment for the youngest victims (13-16 years old)
has been supplemented by psychological group therapy. The group treatment has been carried out as a three-year research project in cooperation between CVS and the Team of Sexually Assaulted Children at Copenhagen University Hospital. Some of the preliminary results have been published, but more research is needed. The possibility of cooperation between professionals of the two centres working with sexually assaulted children and sexually assaulted adults, respectively, forms a unique possibility for mutual inspiration and further research.

The differences of reactions found according to intake of alcohol/drugs before the assault needs to be further examined.

Examination of reactions and needs of treatment and support in relation to closely related to victims of sexual assault is an important field of research, which is on its way at CVS.

**Implications for practice**

It is of importance for clinicians dealing with rape victims to understand how a person reacts to a rape. It is imperative for health care workers in general and psychologists in particular to have a thorough understanding of rape as experienced by the victim. This understanding would need to include an insight into the psychological reactions and recovery processes of the victim. It also needs to include an understanding of the factors present in the context that will influence reactions and recovery. Empirical discovery makes generalisations possible as guidelines for understanding and treatment. The studies of the present research were meant as steps in that direction.

**Ethical considerations**

The present research has been approved and registered by the Danish Data Protection Agency and the Scientific Ethics Committee of Copenhagen and Frederiksberg. The participants in the studies have been treated in accordance with the ethical standards and confidentiality requirements of the Danish Psychological Association (Dansk Psykologforening, 2000).

Each participant has signed an agreement of participation. To minimize the risk of retraumatisation by the follow-up interview each participant was offered a contact with the researcher after the interview.

Participants have given their informed consent under subject anonymity. Identifying elements have been removed from reports.
REFERENCES


### APPENDICES

**APPENDIX A**

**ACUTE STRESS DISORDER SCALE**

<table>
<thead>
<tr>
<th>Question</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Har du på noget tidspunkt under eller efter overgrebet haft en fornemmelse af ikke at kunne mærke dine følelser eller være fjernet fra dem?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Har du på noget tidspunkt under eller efter overgrebet følt dig ør og fortumlet?</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
<td>3. Har du på noget tidspunkt under eller efter overgrebet følt, at ting omkring dig forekom uvirkelige eller drømmeagtige?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Har du på noget tidspunkt under eller efter overgrebet følt dig ”ved siden af dig selv” eller som om, du så det udefra?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Har du på noget tidspunkt været ude af stand til at kunne huske vigtige dele af overgrebet?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Er der ting fra overgrebet, der bliver ved med at dukke op i dine tanker?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Har du haft ubehagelige drømme eller mareridt om overgrebet?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Har du haft en følelse af, at overgrebet var ved at ske igen?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Har du prøvet at undgå at tænke på overgrebet?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Har du prøvet at undgå at tale om overgrebet?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. Har du prøvet at undgå situationer eller mennesker, der minder dig om overgrebet?</td>
<td>1</td>
<td>2</td>
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<td>5</td>
</tr>
<tr>
<td>13. Har du forsøgt at lade være med at være påvirket af overgrebet eller være ulykkelig over det?</td>
<td>1</td>
<td>2</td>
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<tr>
<td>14. Har du haft søvnproblemer siden overgrebet?</td>
<td>1</td>
<td>2</td>
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<td>5</td>
</tr>
<tr>
<td>15. Har du følt dig mere irritabel siden overgrebet?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. Har du haft svært ved at kunne koncentrere dig siden overgrebet?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. Er du blevet mere på vagt overfor ”farer” siden overgrebet?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18. Er du blevet mere urolig/nervøs siden overgrebet?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19. Når du bliver mindet om overgrebet, kommer du så til at svede eller ryste eller slår dit hjerte hurtigere?</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
</tr>
</tbody>
</table>
In American nosology the diagnosis of Acute Stress Disorder (ASD) (American Psychiatric Association, 2000) is employed as description of responses occurring within one month following exposure to extreme stress or trauma (American Psychiatric Association, 2000). The ASD is mainly considered an acute variation of Posttraumatic Stress Disorder (PTSD) (American Psychiatric Association, 2000). Assessment of PTSD can be made after one month post trauma. The main difference between the two diagnoses is that acute responses demand the presence of dissociative symptoms.

Details of ASD are described in the following copy from pp. 469-472 of


308.3 Acute Stress Disorder

Diagnostic Features
The essential feature of Acute Stress Disorder is the development of characteristic anxiety, dissociative, and other symptoms that occurs within 1 month after exposure to an extreme traumatic stressor (Criterion A). For a discussion of the types of stressors involved, see the description of Posttraumatic Stress Disorder (p. 463). Either while experiencing the traumatic event or after the event, the individual has at least three of the following dissociative symptoms: a subjective sense of numbing, detachment, or absence of emotional responsiveness; a reduction in awareness of his or her surroundings; derealization; depersonalization; or dissociative amnesia (Criterion B).

Following the trauma, the traumatic event is persistently reexperienced (Criterion C), and the individual displays marked avoidance of stimuli that may arouse recollections of the trauma (Criterion D) and has marked symptoms of anxiety or increased arousal (Criterion E). The symptoms must cause clinically significant distress, significantly interfere with normal functioning, or impair the individual's ability to pursue necessary tasks (Criterion F). The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks after the traumatic event (Criterion G); if symptoms persist beyond 4 weeks, the diagnosis of Posttraumatic Stress Disorder may be applied. The symptoms are not due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication) or a general medical condition, are not better accounted for by Brief Psychotic Disorder, and are not merely an exacerbation of a preexisting mental disorder (Criterion H).

As a response to the traumatic event, the individual develops dissociative symptoms. Individuals with Acute Stress Disorder may have a decrease in emotional responsiveness, often finding it difficult or impossible to experience pleasure in previously enjoyable activities, and frequently feel guilty about pursuing usual life tasks. They may experience difficulty concentrating, feel detached from their bodies, experience the world as unreal or dreamlike, or have increasing difficulty recalling specific details of the traumatic event (dissociative amnesia). In addition, at least one symptom from each of the symptom clusters required for Posttraumatic Stress Disorder is present. First, the traumatic event is persistently reexperienced (e.g., recurrent recollections, images, thoughts, dreams, illusions, flashback episodes, a sense of reliving the event, or distress on exposure to reminders of the event). Second, reminders of the trauma (e.g., places, people, activities) are avoided. Finally, hyperarousal in response to stimuli reminiscent of the trauma is
present (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, an exaggerated startle response, and motor restlessness).

**Associated Features and Disorders**

Associated descriptive features and mental disorders. Symptoms of despair and hopelessness may be experienced in Acute Stress Disorder and may be sufficiently severe and persistent to meet criteria for a Major Depressive Episode, in which case an additional diagnosis of Major Depressive Disorder may be warranted. If the trauma led to another's death or to serious injury, survivors may feel guilt about having remained intact or about not providing enough help to others. Individuals with this disorder often perceive themselves to have greater responsibility for the consequences of the trauma than is warranted. Problems may result from the individual's neglect of basic health and safety needs associated with the aftermath of the trauma. Individuals with this disorder are at increased risk for the development of Posttraumatic Stress Disorder. Rates of Posttraumatic Stress Disorder of approximately 80% have been reported for motor vehicle crash survivors and victims of violent crime whose response to the trauma initially met criteria for Acute Stress Disorder. Impulsive and risk-taking behavior may occur after the trauma.

**Associated physical examination findings and general medical conditions.**

General medical conditions may occur as a consequence of the trauma (e.g., head injury, burns).

**Specific Culture Features**

Although some events are likely to be universally experienced as traumatic, the severity and pattern of response may be modulated by cultural differences in the implications of loss. There may also be culturally prescribed coping behaviors that are characteristic of particular cultures. For example, dissociative symptoms may be a more prominent part of the acute stress response in cultures in which such behaviors are sanctioned. For further discussion of cultural factors related to traumatic events, see p. 465.

**Prevalence**

The prevalence of Acute Stress Disorder in a population exposed to a serious traumatic stress depends on the severity and persistence of the trauma and the degree of exposure to it. The prevalence of Acute Stress Disorder in the general population is not known. In the few available studies, rates ranging from 14% to 33% have been reported in individuals exposed to severe trauma (i.e., being in a motor vehicle accident, being a bystander at a mass shooting).

**Course**

Symptoms of Acute Stress Disorder are experienced during or immediately after the trauma, last for at least 2 days, and either resolve within 4 weeks after the conclusion of the traumatic event or the diagnosis is changed. When symptoms persist beyond 1 month, a diagnosis of Posttraumatic Stress Disorder may be appropriate if the full criteria for Posttraumatic Stress Disorder are met. The severity, duration, and proximity of an individual's exposure to the traumatic event are the most important factors in determining the likelihood of development of Acute Stress Disorder. There is some evidence that social supports, family history, childhood experiences, personality variables, and preexisting mental disorders may influence the development of Acute Stress Disorder. This disorder can develop in individuals without any predisposing conditions, particularly if the stressor is especially extreme.
Differential Diagnosis
Some symptomatology following exposure to an extreme stress is ubiquitous and often does not require any diagnosis. Acute Stress Disorder should only be considered if the symptoms last at least 2 days and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning or impair the individual's ability to pursue some necessary task (e.g., obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience).

Acute Stress Disorder must be distinguished from a Mental Disorder Due to a General Medical Condition (e.g., head trauma) (see p. 181) and from a Substance-Induced Disorder (e.g., related to Alcohol Intoxication) (see p. 209), which may be common consequences of exposure to an extreme stressor. In some individuals, psychotic symptoms may occur following an extreme stressor. In such cases, Brief Psychotic Disorder is diagnosed instead of Acute Stress Disorder. If a Major Depressive Episode develops after the trauma, a diagnosis of Major Depressive Disorder should be considered in addition to a diagnosis of Acute Stress Disorder. A separate diagnosis of Acute Stress Disorder should not be made if the symptoms are an exacerbation of a preexisting mental disorder.

By definition, a diagnosis of Acute Stress Disorder is appropriate only for symptoms that occur within 1 month of the extreme stressor. Because Posttraumatic Stress Disorder requires more than 1 month of symptoms, this diagnosis cannot be made during this initial 1-month period. For individuals with the diagnosis of Acute Stress Disorder whose symptoms persist for longer than 1 month, the diagnosis of Posttraumatic Stress Disorder should be considered. For individuals who have an extreme stressor but who develop a symptom pattern that does not meet criteria for Acute Stress Disorder, a diagnosis of Adjustment Disorder should be considered. Malingering must be ruled out in those situations in which financial remuneration, benefit eligibility, or forensic determinations play a role.

Diagnostic criteria for 308.3 Acute Stress Disorder
A. The person has been exposed to a traumatic event in which both of the following were present:
   (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   (2) the person's response involved intense fear, helplessness, or horror.

B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:
   (1) a subjective sense of numbing, detachment, or absence of emotional responsiveness
   (2) a reduction in awareness of his or her surroundings (e.g., "being in a daze")
   (3) derealization
   (4) depersonalization
   (5) dissociative amnesia (i.e., inability to recall an important aspect of the trauma).

C. The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts,
feelings, conversations, activities, places, people).

E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.

H. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.
Nedenfor er en liste over vanskeligheder eller problemer, som mennesker kan have, efter at de har været udsat for voldtægt eller voldtægtsforsøg.

Sæt kryds ved det tal, interviewpersonen angiver, som det, der bedst beskriver, hvor ofte hun har oplevet vanskeligheder eller problemer på området **INDENFOR DEN SIDSTE MÅNED.**

**Svarmuligheder:**

<table>
<thead>
<tr>
<th>0</th>
<th>Aldrig eller kun en gang imellem</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>En gang om ugen eller mindre / en gang imellem</td>
</tr>
<tr>
<td>2</td>
<td>To til fire gange om ugen / næsten altid</td>
</tr>
<tr>
<td>3</td>
<td>Fem eller flere gange om ugen / næsten altid</td>
</tr>
<tr>
<td></td>
<td>Hvor ofte.......</td>
</tr>
<tr>
<td>---</td>
<td>-----------------</td>
</tr>
<tr>
<td>1</td>
<td>har du oplevet, at tanker eller billeder fra overgrebet dukkede ufrivilligt op i dit hoved?</td>
</tr>
<tr>
<td>2</td>
<td>har du haft ubehagelige drømme eller mareridt om overgrebet?</td>
</tr>
<tr>
<td>3</td>
<td>har du genopplevet overgrebet på den måde, at du opførte dig som om, det skete igen eller følte det som om, det skete igen?</td>
</tr>
<tr>
<td>4</td>
<td>har du følt dig påvirket følelsesmæssigt, når du er blevet mindet om overgrebet (f.eks. været bange, vred, ked af det, følt skyld eller skam)?</td>
</tr>
<tr>
<td>5</td>
<td>har du haft fysiske reaktioner, som f.eks. svede- eller rysteture, eller hjertebanken, når du bliver mindet om overgrebet?</td>
</tr>
<tr>
<td>6</td>
<td>har du forsøgt ikke at tænke på overgrebet, at tale om det eller forsøgt at lade være med at være påvirket af det?</td>
</tr>
<tr>
<td>7</td>
<td>har du forsøgt at undgå situationer, mennesker eller steder, der mindede dig om overgrebet?</td>
</tr>
<tr>
<td>8</td>
<td>har du været ude af stand til at huske vigtige dele af overgrebet?</td>
</tr>
<tr>
<td>9</td>
<td>har du haft mindre lyst til at deltage i vigtige aktiviteter eller har deltaget mindre i dem?</td>
</tr>
<tr>
<td>10</td>
<td>har du følt dig fjern eller isoleret fra andre mennesker?</td>
</tr>
<tr>
<td>11</td>
<td>har du haft fornemmelsen af, at du ikke kunne mærke dine følelser eller var fjernt fra dem (f.eks. har været ude af stand til at græde, at føle vrede eller glæde)?</td>
</tr>
<tr>
<td>12</td>
<td>har du følt det, som om dine planer og håb for fremtiden ikke bliver til noget (f.eks. i forhold til arbejde/uddannelse, familie eller venner)?</td>
</tr>
<tr>
<td>13</td>
<td>har du haft søvnproblemer?</td>
</tr>
<tr>
<td>14</td>
<td>har du været mere irritabel eller vred end før overgrebet?</td>
</tr>
<tr>
<td>15</td>
<td>har du haft svært ved at koncentrere dig (f.eks. mister tråden i en samtale, kan ikke følge med i et Tv-program, glemmer det, du lige har læst)?</td>
</tr>
<tr>
<td>16</td>
<td>har du været ekstra meget på vagt (f.eks. at du holder øje med, hvem der er omkring dig, føler dig utilpas med ryggen til døren)?</td>
</tr>
<tr>
<td>17</td>
<td>har du været nervøs eller er blevet let forskrækket (f.eks. hvis nogen nærmer sig bagfra)?</td>
</tr>
</tbody>
</table>

mindre end tre måneder og en kronisk og forsinket PTSD med en længere varighed. Nedenstående figur viser tidslinien mellem ASD og PTSD (Yehuda & Wong, 2000).

Diagnostiske kriterier

Diagnosen PTSD kræver at følgende kriterier opfyldes (American Psychiatric Association, 2000):

A. **Personen har været udsat for en traumatisk begivenhed, hvor**


Voldtægt og voldtægtsforsøg falder indenfor kriterierne, både hvad angår ofrene selv, vidner til overgrebet samt nære pårørende.

2. Personens reaktion omfattede intens frygt, hjælpeløshed eller rædsel.

Efter oplevelsen af den belastende hændelse kan personen have nogle eller alle af følgende 17 symptomer af forskellig styrke (American Psychiatric Association, 2000; Hougaard, Rosenberg & Nielsen, 2002):

B. **Genoplevelse (1-5)**

1. Tilbagevendende og påtrængende ubehagelige erindringer om begivenheden i enten forestillingsbilleder, tanker eller oplevelser.
2. Tilbagevendende ubehagelige drømme om oplevelsen.
3. Adfærd eller føelser som om den traumatiske begivenhed fandt sted på ny (er forbundet med en følelse af at genoplive hændelsen, illusioner, hallucinationer og dissociative flashback episoder, inklusive sådanne, der kan finde sted, når man lige er vågent eller beruset).
4. Intenst psykologisk ubehag ved udsættelse for interne eller eksterne cues, der symboliserer eller minder om aspekter ved den traumatiske hændelse.
5. Fysiologisk reaktivitet ved udsættelse for interne eller eksterne cues, der symboliserer eller minder om aspekter ved den traumatiske hændelse.

C. Undgåelsesreaktioner (6-12), som angivet ved tre (eller flere) af de følgende:

7. Bestræbelser på at undgå aktiviteter, steder eller mennesker, der vækker erindringer om traumet.
8. Manglende evne til at genkalde et vigtigt aspekt ved traumet.
10. Følelse af afsonderede eller tilbagetrækning fra andre.

D. Forhøjet alarmberedskab (13-17) angivet ved to (eller flere) af de følgende:

15. Koncentrationsvanskeligheder.
17. Forstærket ‘fare-sammen-reaktion’.

E. Varigheden af lidelsen (symptomer i kriterium B, C og D) er mere end en måned.

F. Lidelsen forårsager klinisk signifikant ubehag eller forringelse på sociale, arbejdsmæssige eller andre vigtige funktionsområder.
Copenhagen Rape Experience Interview (CREI)

Tillægsspørgsmål til opfølgning på reaktioner

1. Forhold vedrørende overgrebet
2. Påvirkningsfaktorer efter overgrebet
3. Individuelle reaktioner på overgrebet

"Tilpasning" efter overgrebet:
Acute Stress Disorder: Ja ____ Nej ____
Posttraumatic Stress Disorder: Ja ____ Nej _____

Sagsnummer:___________________________   Dato:__________________________________

1.1. Kan du med få ord sige noget om, hvad det var, der gjorde, at det blev til en voldtægt/et voldtægtsforsøg?
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

1-6 udfyldes af interviewer ud fra svar på 1.1.:
1. At jeg var/ikke var påvirket af alkohol /drug
2. At gerningsmand var påvirket af alkohol/drug
3. At jeg græd/bad ham stoppe
4. At jeg gjorde modstand
5. At nogen kom til hjælp
6. Andet

_______________________________________________________________________________

1.2. Hvad prøvede du at gøre for at komme ud af situationen?
_______________________________________________________________________________
_______________________________________________________________________________

1.2.1. Oplevelse af egen modstand: Passiv modstand (sige nej, vende sig væk ell. l.)____
Verbal (råb, skrig)_____ Fysisk (skub, spark, slag, bid, riv)_____
1.3. Var du bange for, at han skulle slå dig? Ja_______ Nej________

1.4. Følte du dig truet på livet? Ja_____ Nej________

1.5. Var du bange for at dø? Ja_______ Nej________

1.6. Hvad synes du i det hele taget var det værste?
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

2.1. Synes du, at du har fået den støtte fra familie og andre, som du har brug for?  
Ja____ Nej_______
(Scores som ja, hvis én af forældrene eller anden nærtstående person angives som god støtte).
_______________________________________________________________________________
_______________________________________________________________________________

2.2.1. Hvordan synes du, at din mor i det hele taget har været som forælder for dig?  
Meget omsorgsfuld __ nogenlunde omsorgsfuld __ Ikke omsorgsfuld__

2.2.2. Hvordan synes du, at din far i det hele taget har været som forælder for dig?  
Meget omsorgsfuld __ nogenlunde omsorgsfuld __ Ikke omsorgsfuld__

2.3. Er der noget udover overgrebet, som du i dag umiddelbart vil sige, har været meget belastende? 
Nej __
Ja____
Hvad?__________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

2.3.1 Selv om, der svares nej på 2.3. nævnes alle spørgsmål under 2.3. for alle:  
Hvis du skulle svare enten ja eller nej i forhold til belastning, hvad vil du så svare i forhold til

2.3.1.1. Politiafhøring: Ja____ Nej____

2.3.1.2. Retsforløb: Ja____ Nej____

Hvis ikke politianmeldt, nævn den vigtigste grund:
_______________________________________________________________________________
_______________________________________________________________________________

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2.3.1.3. Lægelig /retsmedicinsk undersøgelse: Ja_____ Nej____
2.3.1.4. Arbejdspres /eksamen eller andre faktorer: Ja___ Nej____
2.3.1.5. Omgivelsernes reaktion: Ja___ Nej____

3.1. Bebrejder du dig selv, at overgrebet er sket? Ja___ Nej_____ 
3.2. Føler du, at andre har ændret holdning til dig efter overgrebet? Ja___ Nej_____ 

Hvis ja, så hvordan?
____________________________________________________________________________
_____________________________________________________________________________

3.3. Synes du, at dine spisevaner har ændret sig? Ja______ Nej______
3.3.1. Hvis ja: Er det et problem for dig? Ja______ Nej______
3.4. Har du tidligere haft spiseproblemer? Nej______ Ja______ Hvilke?
_____________________________________________________________________________

3.5. Er dit forbrug af alkohol steget? Ja______ Nej______
3.5.1. Hvis ja: Er det et problem for dig? Ja______ Nej______
3.6. Er dit forbrug af medicin eller narkotiske stoffer steget? Ja___ Nej_____
3.6.1. Er det et problem for dig? Ja______ Nej______

3.7. Har du fysiske gener, som du ikke havde før overgrebet? (eks. hovedpine, mavepine, muskelspændinger, underlivsproblemer, smelter) Nej ____ Ja______ 

Hvilke?
_____________________________________________________________________________

3.8. Har du følt dig mere alene efter overgrebet? Ja____ Nej_____ 
3.9. Har du forsøgt at gøre dig selv skade? Nej____ Ja______ 

Hvordan?
_____________________________________________________________________________

Hvis nej på 3.9. besvar 3.10.
3.10. Har du haft tanker om at skade dig selv? Ja____ Nej_____ 

3.11. Har dit syn på mænd og sex ændret sig? Nej ____ Ja______ 

Hvis ja, hvordan?
3.11.1. Det er blevet bedre ⬆
3.11.2. Det er blevet dårligere ⬇

3.12. Hvordan opstod tanken om at gå i psykologisk behandling?
3.12.1. Mit eget ønske
3.12.2. Forslag fra modtagende læge/sygeplejerske
3.12.3. Min familie/venner synes, at jeg skulle
3.12.4. Andet

Hvordan?

3.15. Har du forslag til, hvordan hjælp og støtte efter et seksuelt overgreb kunne gøres bedre?

Interviewerens notater:

Systematisering af cases i hovedtyper i forhold til psykologisk intervention

1. Antal behandlinger:
2. Andet:

Manual til interview

Tak fordi du ville komme.
Jeg hedder Signe og er psykologistuderende på sidste del af studiet.
Det er mig, der skal interviewe nogle af dem, der har været i psykologisk behandling på centret.
Grunden til, at det er mig, som du ikke kender, du møder, er, at interviewet her skal være så
neutralt som muligt, fordi det skal indgå i et forskningsprojekt. Hvis du efter interviewet føler, at
du har brug for en samtale med Annalise, har hun sagt, at du er velkommen til at ringe til hende og
aftale en tid.
Det, interviewet går ud på, er at få et indtryk af, hvordan du har det nu, et stykke tid efter, at du har
afsluttet behandlingen.
Interviewet skal bruges til at finde frem til den bedste behandling for dem, der får kontakt med
Center for Voldtægtsofre.
Interviewet består af to dele:
Den ene del er en række spørgsmål om, hvilke reaktioner, du synes, du har nu. Den anden del er
nogle spørgsmål om andet, som måske kan have indflydelse på, hvordan du har haft det og har det
nu.
APPENDIX D

The Rape Trauma Syndrome
Before the occurrence of the PTSD diagnosis Burgess and Holmstrom (1974) studied reactions in victims of forcible rape and attempted forcible rape. They found characteristic symptoms in the victims and proposed for these a special Rape Trauma Syndrome (RTS). The diagnosis is still in use to day (St. Mary’s Sexual Assault Referral Centre, 2004) and has several characteristics in common with both ASD and PTSD as shown in Table D.

Table D. Comparison between RTS, ASD, and PTSD

<table>
<thead>
<tr>
<th></th>
<th>ASD (2days-4weeks)</th>
<th>RTS acute phase (0 days-2-3weeks)</th>
<th>RTS second phase (&gt;3weeks)</th>
<th>PTSD (&gt;1month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissociation</td>
<td></td>
<td>Disorganization: Controlled emotional style</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invasion</td>
<td>Impact reactions/ extrovert emotional style</td>
<td>Nightmares</td>
<td>Reexperiencing</td>
<td></td>
</tr>
<tr>
<td>Avoidance</td>
<td>Increased motor activity/ Traumatophobia</td>
<td></td>
<td>Avoidance</td>
<td></td>
</tr>
<tr>
<td>Fear/Hyperarousal</td>
<td>Somatic reactions/extrovert emotional style/ Emotional reactions</td>
<td>Traumatophobia</td>
<td>Arousal</td>
<td></td>
</tr>
</tbody>
</table>

The diagnoses are all self reported and describing a mental condition that may occur following exposure to extreme stress or trauma.

The part of RTS describing the controlled emotional style (masked or hidden feelings and calm, composed or subdued affect) resembles the dissociation of ASD. The expressed/extrovert emotional style of RTS (Fear, anger, and anxiety shown through crying, sobbing, smiling, restlessness, and tenseness) resembles the symptoms of invasion and fear/hyperarousal of ASD. The RTS emotional reactions (fear, humiliation, embarrassment, anger, revenge, self-blame) resemble fear/ hyper-arousal symptoms of ASD.

A comparison between long-term RTS reactions and PTSD also indicate overlap: Nightmares of RTS are described as symptoms of reexperiencing. The increased motor activity in the form of changing telephone number or residence may be understood as avoidance reactions as well as part of the traumatophobia (fear of indoors and outdoors; fear of being alone; of crowds; fear of people behind you, and sexual fears).

The phenomenon of traumatophobia also overlaps the arousal symptoms of PTSD.

The RTS include typical physical disturbances in rape victims such as pain, nausea, loss of appetite and gynaecological symptoms.

Although ASD and PTSD do not encompass these disturbances it is suggested that the trauma reactions Burgess & Holmstrom found in rape victims resemble reactions to other traumas in so many respects that there is no need of a specified diagnosis. The source and the personal
experience of the trauma rather seem to affect severity than type of reactions (McFarlane & Girolamo, 1996). Besides it is a great relief to most victims of rape to know that their reactions are “normal” reactions also seen in other survivors following extreme stressful events. It may decrease stigmatisation.
APPENDIX E

Comparison between assessments of Acute Stress Reaction (ASR) and Acute Stress Disorder in 50 victims of rape and attempted rape.

The ASR state occurs within an hour after after the trauma (ICD-10, 1994) and wears off in a few days, maximum two or three days. The symptoms are varied and shifting. By way of introduction a state of daze is seen with some narrowing of awareness and attention. Diminished sensibility and disorientation is seen. The state may be followed by anxiety symptoms (nervousness, shivering, muscle tensions, increased sweating, dullness, increased heart beat, dizziness and stomach pain), plus retrieval, narrowing of consciousness, desorientation, anger or verbal aggression, despair or hopelessness, exaggerated or purposeless hyperactivity, uncontrolled and exaggerated reaction of sorrow.

Responses of ASR in the 50 women participating in the study of acute reactions to rape and attempted rape (N=50) (Article I)

<table>
<thead>
<tr>
<th>ASR reactions (N=50)</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal or no reaction</td>
<td>35 (70)</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>9 (18)</td>
</tr>
<tr>
<td>Despair/hopelessness</td>
<td>6 (12)</td>
</tr>
<tr>
<td>Anxiety reactions</td>
<td>3 (6)</td>
</tr>
<tr>
<td>Disorientation</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Anger</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
</tr>
</tbody>
</table>

At the first contact with the centre, the doctor and nurse at the admission ward assess the reactions of the victim according to Acute Stress Reaction (ICD-10, 1994). There was no concordance between the assessment of Acute Stress Reaction and the assessment of Acute Stress Disorder in the 50 women. 70% of the women are assessed as having a ‘normal or no stress reaction’ in the ASR assessment (some have more than one reaction therefore the total sum is more than 50) while the ASD study found that 88% of the same women a few days later were assessed as suffering from ASD. From this can be drawn that even if the victims may seem rather unaffected outwardly, they may be seriously affected by the assault. This is an important notion in securing accessibility of a psychological contact in the aftermath.
Kære

Der er gået snart fem år siden Center for Voldtægtsofre på Rigshospitalet åbnede.

For at sikre den bedst mulige behandling gennemføres nu en opfølgning i forhold til dem, der har haft kontakt med centret.

Jeg kontakter dig, fordi jeg er i gang med en undersøgelse i forhold til den psykologiske behandling, som centret tilbyder.

Undersøgelsen gennemføres som interview af ca. en times varighed, som jeg håber, at du har mulighed for at deltage i.

Interviewet vil foregå i Juliane Marie Centret på afsnit 4032. Der er afsat tid til interview med dig d. 15.2.05 kl. 15-16.

Er tidspunktet ubelejligt, håber jeg, at du vil ringe mig op på tlf. 3445 4741, så der kan findes en tid, der passer for dig.

Har du i øvrigt spørgsmål om interviewet, må du også meget gerne ringe til mig.

Af hensyn til, at undersøgelsen kan være så neutral som mulig, vil interviewet blive foretaget af Signe Rakel Sørensen, som er tilknyttet centret.

Har du behov for at tale med mig efter interviewet, er der også mulighed for det. Du kan ringe mig op direkte eller bede Signe om, at jeg kontakter dig.

Undersøgelsen vil indgå i en efterfølgende publikation, hvor du naturligvis er sikret fuld anonymitet.

De økonomiske udgifter, du kan have i forbindelse med at deltagte i interviewet, vil blive dækket.

Med venlig hilsen

Annalise Rust
Kære
Jeg har fuld forståelse for, at du måske ikke ønsker at deltage i det opfølgende interview, jeg har inviteret dig til, men det er en vigtig information for centret at vide, hvad grundene kan være til, at man ikke ønsker at deltage.
Hvis det ikke er for meget ulejlighed, vil jeg meget gerne have et par ord fra dig om det. Det skal som sagt bruges i forbindelse med at udvikle bedst egnete behandlingsmetoder for de mennesker, der kommer i kontakt med centret.
Du kan skrive til mig på min mailadresse eller pr. brev. Du er også velkommen til at ringe til mig.

Hvis du var forhindret i at komme d. 17.2. og gerne vil komme på et andet tidspunkt, der passer dig bedre håber jeg, at du vil ringe mig op på tlf. 35 45 47 41 eller 3545 7315.

Med venlig hilsen

Annalise Rust
Samtykkeerklæring angående forskningsprojekt ved psykolog Annalise Rust, Center for Voldtægtsofre

Forskningsprojektet drejer sig om en undersøgelse i forhold til dem, der har modtaget psykologisk behandling i centret. Undersøgelsen gennemføres med henblik på at sikre den bedst mulige behandling.

Undersøgelsen foretages som interview.

1. Jeg er orienteret om undersøgelsens formål og anvendelse.

2. Jeg er indforstået med at stille mig til rådighed med et interview i forbindelse med undersøgelsen.

3. Jeg er indforstået med, at interviewet i anonymiseret og redigeret form vil indgå i efterfølgende publikationer.

4. Jeg er indforstået med, at jeg på et hvilket som helst tidspunkt kan afbryde min deltagelse i undersøgelsen og trække mit bidrag tilbage.

5. Jeg er indforstået med at blive kontaktet ved en senere opfølgningsundersøgelse, hvis en sådan skulle finde sted.

Navn......................................................................................................................

Adresse...............................................................................................................  

Tlf.nr....................................................................................................................

_________________________________________________  

Dato og underskrift
24. kapitel

Forbrydelser mod konssædeligheden

§ 216. Den, der tiltvinger sig samleje ved vold eller trussel om vold, straffes for voldtægt med fængsel indtil 8 år. Med vold sidestilles hensættelse i en tilstand, i hvilken den pågældende er ude af stand til at modsætte sig handlingen.

  Stk. 2. Straffen kan stige til fængsel i 12 år, hvis voldtægten har haft en særlig farlig karakter eller der i øvrigt foreligger særligt skærpende omstændigheder.

§ 217. Den, som skaffer sig samleje ved anden ulovlig tvang, jf. § 260, end vold eller trussel om vold, straffes med fængsel indtil 4 år.

26. kapitel

Forbrydelser mod den personlige frihed

§ 260. Med bøde eller fængsel indtil 2 år straffes for ulovlig tvang den, som

  1) ved vold eller ved trussel om vold, om betydelig skade på gods, om frihedsberøvelse eller om at fremsætte usand sigtelse for strafbart eller ærerørigt forhold eller at åbne privatlivet tilhørende forhold tvinger nogen til at gøre, tåle eller undlade noget,

  2) ved trussel om at anmelde eller åbne et strafbart forhold eller om at fremsætte sande ærerørigte beskyldninger tvinger nogen til at gøre, tåle eller undlade noget, for så vidt fremtvingelsen ikke kan anses tilbørlig begrundet ved det forhold, som truslen angår.
Pilot-study on self-reported complaints (2000)

OVERORDNET SPØRGSMÅL:
I Hvad optager dig mest (fylder mest) nu? (½ år efter voldtægten / voldtægtsforsøget)

II (Afhængig af svar på I) Spørgsmål ud fra 1) kropslige / somatiske reaktioner / problemer, 2) Følelsesmæssige reaktioner / vanskeligheder. 3) Kontaktmæssige reaktioner / vanskeligheder, 4) Tankemæssige (Kognitive) reaktioner / problemer.

III Spørgsmål til hvert område (1 – 4)
(IES, SCL–90, SCL-92, TSC-33 checklister udbygget med egne spørgsmål)

IV Effekten af psykologkontakten.

V Udvikling / ændring i reaktioner fra overgrebstidspunktet til nu:

VI Reaktioner / vanskeligheder før overgrebet sammenlignet med nu? (Få det ind, måske som afsluttende spørgsmål under hver deltest: Er der noget af det, Du har kendt før?)

Overordnet spørgsmål for hvert delområde (derefter detaljespørgsmål og rubrikker, der kan krydses af undervejs eller efter som check).

- Hvordan synes du, at det har påvirket dig kropsligt?
- Hvordan synes du, at det har påvirket dine følelser?
- Hvordan synes du, at det har påvirket dit forhold til andre?
- Hvordan synes du, at det har påvirket dine tanker?

Køre med numre, f.eks.: I. 1.a, II. 2.c…. Give numre efter de skalaer, spørgsmålene er taget fra.

Somatiske / kropslige symptomer:
Har du problemer med mave, underliv, menstruation (kvalme – uro)?

Har du hovedpine?

Hvordan har du det med appetit / spisning?

Er du generet af svimmelhed eller tilløb til at besvime?

Har du problemer med vejrtrækningen?

Er du generet af smertes i hjerte eller bryst? – Generet af hjertebanken?

Er du generet af følelsesløshed eller snurrende fornemmelse i kroppen?
Generes du af rysten / sitren?
Generes du af muskelsmerter / infiltrationer?
Får du medicin? – Hvilken?
Hvor ofte indtager du alkohol?
Har du været syg indenfor det sidste halve år og med hvad?
Har du konsulteret en læge indenfor det sidste halve år og af hvilken grund?
Har du været indlagt på hospital?
Tænker du på, om du fejler noget?
Vasker du dig meget – overdreven hygiejne?
Vejer du mere eller mindre end før voldtægten?
Hvordan har du det med din krop?
Gør du noget for at holde din krop i form?

**Følelsesmæssige symptomer:**
Hvordan sover du? (Urolig søvn / mareridt / indsovningsproblemer / vågner og kan ikke falde i søvn igen / sover meget / sover lidt / har svært ved at vågne om morgenen)
Har du sexuelle problemer?
Føler du dig trist?
Har du let til gråd?
Føler du dig bange?
Føler du dig på vagt?
Har du humørsvingninger? – Svært ved at styre dine følelser?
Føler du dig vred og irriteret?
Har du ønsker om at skade / straffe dig selv?
Har du ønsker om at skade / straffe andre?
Føler du dig underlegen eller usikker?
Har du selvbebrejdelser?
Har du følelse af uvirkelighed?

Føler du, at det nogle gange er, som om du er ude af din krop?

Føler du dig anspændt?

Føler du dig uoplagt?

Er du generet af nervøsitet eller indre uro?

Har du en følelse af, at du let bliver ærgerlig eller irriteret?

Er du ængstelig / bange når du færdes alene ude?

Føler du dig bange, når du er alene hjemme?

Føler du dig træt og mangler energi? (Generes du af manglende energi og træthed?)

Oplever du, at du kan blive pludseligt bange uden grund?

Hvor meget er du generet af vredesudbrud, som du ikke kan kontrollere?
Føler du dig nedtrykt?

Er du bekymret over noget? (Er der noget, der bekymrer dig?)

Er der noget, du er bange for?

Hvad kan gøre dig glad? – Ked af det? – Vred?

Hvad stresser dig / gør dig rastløs / utålmodig?
Hvad kan gøre dig nervøs / usikker

Er der noget, der særligt engagerer dig?

Hvad betyder noget for dig?

Hvad har din særlige interesse?

Hvad kan få dig til at føle dig ensom og alene?

Hvad sætter du pris på ved dig selv?

Hvordan vil du beskrive dit humør / grundstemning?

**Kontaktmæssige vanskeligheder:**

Føler du dig isoleret fra andre?

Føler du dig ensom?
Hvordan kommer du af det med andre?

Hvordan har du det med mænd – mænd du kender – ikke kender – mænd ældre end dig selv / yngre / samme alder som dig selv – danskere – anden etnisk baggrund end dansk?

Vil du betegne dig selv som sexuelt meget aktiv?

Vil du betegne dig selv som sexuelt tilbageholdende?

Hvordan har du det med kvinder?

Hvordan er din tillid / tryghed ved andre mennesker? – Føler du, at du kan stole på andre?

Hvad tror du andre synes om dig?

Hvad tror du andre sætter pris på ved dig?

Hvad tror du andre siger om dig?

Hvad tror du andre tænker om dig?

Hvordan har du det, når andre kigger på dig (mænd – kvinder – børn)?

Er der nogen, du føler dig tæt knyttet til?

**Tankemæssige / kognitive symptomer:**

Har du forstyrrende tanker eller billeder (flash-backs)?

Taber du tråden; forsvinder du i dine tanker?

Har du problemer med at huske?

Gentagne ubehagelige tanker, som du ikke kan få ud af hovedet?

Har du svært ved at træffe beslutninger?

Er du nødt til at kontrollere alt, hvad du gør igen og igen?

Hvad lægger du mest mærke til hos andre? (Hvad lægger du først mærke til?)

Hvad lægger du mest mærke til, når du er nye steder?

Hvad tænker du om dig selv?

Hvordan ser du på fremtiden?
APPENDICES REFERENCES


